

Evidence Summary

Behavioral Health Services for Transition-Age Youth

Who Are Transition-Age Youth?

Transition-age youth are people between the ages of 16 and 25. Individuals in this age group are at high risk for substance use and mental health disorders, but they are also among those least likely to seek help. Many who have previously received services as youth fail to receive continued services as they move into the adult health care system (Now Is the Time, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2009a). Given the vulnerabilities of this age group, they can benefit from additional social and behavioral health supports to promote healthy life-course trajectories.

As the family's influence diminishes, transition-age youth also experience major changes related to education, vocation, and relationships (Sheidow, McCart, Zajac, & Davis, 2012). Although most 16- and 17-year-olds live at home with kin or in foster care, by age 18, emerging adults begin to live semi-autonomously, residing at home while in college or while working. Others reside on their own, living alone, with housemates, or romantic partners. Some are high school and college students, while others drop out of school or take circuitous and extended routes to obtain educations. All transition-age youth experience varying economic uncertainties, but working-class and lower-income youth face challenges different from youth whose families continue to provide financial support (Silva, 2012).

Given these changes, social science researchers consider transition-age youth to be part of the developmental stage of "emerging adulthood" (ages 18–25), a period of life that is "theoretically and empirically distinct" from adolescence and adulthood (Arnett, 2000, p. 469). During this period, "little about the future has been decided for certain" and "many different directions remain possible" (p. 469). The uncertainties that characterize this period of development are captured by the five themes Arnett (2014) proposed as characterizing this stage: "identity exploration, instability, self-focus, feeling in between, and possibilities/optimism" (p. 158).

Challenges Facing Transition-Age Youth

Some researchers have focused on the challenges faced by youth as they transition to adult health care and social services. Youth with specialized behavioral and physical healthcare needs are more vulnerable and face more complex challenges as they emerge as adults (Manteuffel, Stephens, Sondheimer, & Fisher, 2008). They are at increased risk for co-occurring mental illness and substance use disorders; suicidal ideation and suicide; unemployment and homelessness; unplanned pregnancy and parenthood; and involvement with the criminal justice system (Berzin & De Marco, 2010; Heflinger & Hoffman, 2006; Sheidow et al., 2012; SAMHSA, 2013;

SAMHSA, 2014b; Williams & Sheehan, 2015). Many transition-age youth are at risk for severe mental illness, because the onset of schizophrenia, mood disorders, and substance use disorders “peak during this period” (Burt & Paysnick, 2012, p. 495).

Using data from the National Longitudinal Survey of Youth, Berzin (2010) distinguished successful and unsuccessful transition-age youth, dividing the sample into four classes. Youth in class 1 (29 percent) and class 2 (46 percent) were the more successful youth, who reported low rates of teen parenting or welfare use, low rates of arrests or drug use, and low rates of homelessness. Youth in class 1 were non-college bound, and 1/3 experienced poverty in adulthood; youth in class 2 attended or graduated from college, but 40 percent experienced poverty. In contrast, the less successful youth in class 3 (9 percent) had more significant problems, and over 50 percent of that segment dropped out of high school and experienced either arrest, poverty, teen pregnancy, or drug use. Finally, class 4 (16 percent) had “multiple social problems” (p. 490), including high rates of teen pregnancy, poverty, and low educational attainment (33 percent dropped out of high school; 15 percent attended college). Over 90 percent of class 4 youth used “public assistance at some point during emerging adulthood” (p. 490).

Berzin (2010) underscored the challenge of understanding the complex interaction of factors influencing resiliency and vulnerability. The needs of transition-age youth and the complex impact of multiple factors are highlighted by the most vulnerable of these transition-age youth, such as those with severe mental illnesses or substance use disorders, youth who transition out of foster care, youth who are impoverished and homeless, and youth who are racial and ethnic minorities.

Youth with Mental Illness and Substance Use Disorders

The development of serious mental illnesses and/or substance use disorders presents one of the major challenges for youth transitioning into adulthood, especially as they try to access systems of adult health care and social services. Serious mental illness is defined as the presence of significant functional impairment in addition to a diagnosed psychiatric disorder, such as mood disorders, anxiety disorders, schizophrenia, and substance use disorders (Sheidow et al., 2012). In 2012, “nearly 20 percent of young adults, age 18–25 living in U.S. households, had a mental health condition...and of these, more than 1.3 million had a disorder so serious that their ability to function was compromised” (SAMHSA, 2013, p. 1). According to McGorry (2011), “the transition to adulthood is the period during which nearly all the potentially serious mental disorders that disable or kill during the ensuing decades of adult life have their onset” (p. 524). Approximately 75 percent of mental and substance use disorders appear before age 25, and “the peak 12-month prevalence for any disorder across the lifespan” occurs between the ages of 16 and 24 (McGorry, p. 526).

Mood disorders, such as major depression and bipolar disorder, are the most prevalent serious mental illnesses among transition-age youth. Studies based on data from the National Survey on Drug Use and Health (NSDUH; SAMHSA, 2014a) reported that 11.2 percent of youth ages 16–17 had a major depressive episode in the past year. Of those, 39.9 percent received treatment

60.1 percent did not. Mood disorders generally increased with age, such that 17- and 18-year-olds had twice as many mood disorders as younger adolescents, suggesting an increased risk of a major depressive episode among transition-age youth. Manteuffel and colleagues (2008) found mood disorders to be the most common of diagnoses among all transition-age youth receiving services from 45 federally funded systems of care, such as mental health and substance abuse services for children and their families

Although anxiety can develop at any age, anxiety disorders, such as posttraumatic stress disorder (PTSD) and social phobia, become more widespread as youth transition to adulthood, particularly as they begin to live independently. Findings from the Great Smoky Mountains Study, a longitudinal study of 1,420 youths ages 9–26, confirmed that the transition to adulthood is marked by increases in anxiety disorders, influenced by psychosocial factors such as living autonomously and finding employment (Copeland, Angold, Shanahan, & Costello, 2014). “By their mid-20s, a quarter of subjects had met criteria for an anxiety disorder” (Copeland et al. 2014, p. 9).

One of the most serious mental illnesses to begin during late adolescence is schizophrenia spectrum disorder, a severe brain disorder marked by psychosis and major cognitive deficits. Researchers continue to examine and debate the reasons why the first onset of schizophrenia tends to occur at this age. Uhlhaas (2011) said, “aberrant anatomical development during adolescence may be genetically influenced but environmental factors may also have a role” (p. 481). Although brain maturation during adolescence is thought to be part of the cause, the precise pathways have not been identified to predict schizophrenia’s development. Incidence data suggest approximately 100,000 people in the United States experience a first onset of psychosis each year (Insel, 2015), but exact figures for schizophrenia’s onset are unknown.

Co-occurrence or comorbidity of serious mental illnesses and substance use disorders exist among transition-age youth more than any other developmental age (Sheidow et al., 2012). “Comorbidity is so common that dual diagnosis should be expected rather than considered an exception” (Minkoff, 2001, p. 598). Although it is normal for emerging adults to experiment with substances, the co-occurrence of substance use with serious mental illness complicates youth functioning. Findings from the combined 2010 and 2012 NSDUH (SAMHSA, 2014a) study revealed 2.2 million (6.4 percent) people ages 18–25 had substance use disorder combined with any mental illness, while 555,000 (1.6 percent) had co-occurring substance use disorder and serious mental illness, such as schizophrenia and major depression. Outcome studies report that transition-age youth who have substance use disorders that co-occur with serious mental illness are at an exceptionally greater risk for poor outcomes compared with youth from any other age group with serious mental health problems (Manteuffel et al., 2008).

Youth Transitioning Out of Foster Care

Young people age out of foster care when they reach the age of legal adulthood – generally age 18, although many states now provide services until youth are 21 years of age (Administration for Children & Families [ACF], 2015). Of the estimated 400,540 youth in foster care in 2011, 26,286 (11 percent) aged out of foster care (ACF, 2012). Without a parental safety net to support their transition into independent living, “former foster youth arrive at the shores of adulthood

on waves of disrupted family backgrounds, disjointed foster care experiences, and marked vulnerabilities that undermine their adaptive negotiation of age-salient challenges” (Yates & Grey, 2012, p. 475).

Foster care is mandated to provide protection for abused and neglected children. Thus, the majority of youth come into care with family histories of trauma. Their trauma histories place them at increased risk for PTSD or other forms of mental health disorders (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Studies of adolescents in foster care suggest that those of transition age have approximately twice the lifetime prevalence of PTSD than their peers in the general population (Salazar, Keller, Gowen, & Courtney, 2013).

The Casey Family National Foster Care Alumni Study reported that 90 percent of people formerly in foster care had maltreatment histories prior to entering foster care and “21 percent reported maltreatment that occurred while they were in foster care” (Salazar et al., 2013, p. 3). In this study, females had nearly twice the rate of depression as males (18.5 percent compared with 9.5 percent, respectively) and three times the rate of PTSD (30.6 percent compared with 11 percent, respectively). Both “females and males with depression and PTSD also had extremely high rates of comorbidity” (Pecora et al., 2009, p. 6).

Co-occurring mental, physical, and substance use disorders are common among youth who have experienced trauma, but few studies have specifically evaluated co-morbidity among transition-age foster youth (Pecora et al., 2009). Findings from the Northwest Alumni Study of people between the ages of 20 and 33 who were formerly in foster care demonstrate that 20 percent of participants had three or more psychiatric disorders compared with 3 percent of the general population. Another study of African American and white people formerly in foster care found 98 percent of participants exhibited co-morbid depression and 94 percent had comorbid PTSD (Pecora et al.).

Homeless and Impoverished Youth

“Poverty is a consistent risk factor across multiple domains of development” (Hardaway & Mcloyd, 2009, p. 242), such as academic achievement, employment attainment, and independent living. Although all youth who experience poverty are not homeless, the experience of homelessness is an added risk factor for transition-age youth. Transition-age youth may have experienced homelessness when they were younger and living with adult relatives who were homeless; they may have become homeless when they left home to escape abuse, or their relatives abandoned them; or they may have become homeless when they left the foster care system, yet were too poor to live on their own. Both homelessness and poverty place transition age youth at risk of poor health due to poor nutrition, substance use, and risky sexual behaviors. For example, most youth who are homeless lose benefits and support from previous systems of care, such as public assistance or foster care. As a result, Wenzel and colleagues (2012) said that homeless youth, ages 18–25, “are among the most marginalized individuals in the United States” (p. 561).

The few studies focused on homeless youth report the existence or composition of social network ties, which tend to be street- or relative-based ties (Johnson, Whitbeck, & Hoyt, 2005; Wenzel et al., 2012). Youth who are homeless generally are estranged from their families, but Johnson and colleagues (2005) suggest that homeless girls are more in touch with relatives than homeless boys. Also, compared to heterosexual homeless youth, lesbian, gay, and bisexual homeless youth are more involved with street acquaintances (Johnson et al.). The risk of being associated with street-based networks is that youth are exposed to “individuals who are resource poor and who engage in the most deviant behaviors” (Wenzel et al., p. 567), such as substance use and risky sex.

Racial and Ethnic Minority Youth

A number of studies comparing racial and ethnic groups in the United States confirm that cultural variations exist among youth emerging as adults (see, for example, Arnett, 2003; Syed & Mitchell, 2013). Further, many youths with special health care needs face racial and ethnic disparities regarding adequate preparation for obtaining adult health care services as they transition into adulthood (Lotstein, Kuo, Strickland, & Tait, 2010), and “well-described gaps in access to health care” (p. 129) exist for minority youth. In a review of the influence of race and economic status on mobility among transition-age youth, Hardaway and Mcloyd (2009) concluded that “historical and present-day institutional racism and discrimination have contributed greatly to the disadvantaged status of African Americans” (p. 17). These factors add to the challenges that African American youth face as they transition into adulthood, whether they are lower class, working class, or more socially and economically privileged (Arnett, 2003; Hardaway & Mcloyd, 2009).

For example, Hammond’s (2012) study of African American men found that the racism young men experienced was associated with symptoms of depression. Stress, masculine role norms, socioeconomic factors, and higher restrictions of emotions influenced the symptoms. The cultural tendency “to take everyday racial discrimination like a man” (Hammond, 2012, p. 239) may contribute to stress, leading to health disparities among African American transition-age youth.

Lotstein and colleagues (2010) indicated that the transition to adulthood is far more challenging for Hispanic and African American youth, in part due to socioeconomic factors. Low income compounds the challenges for youth who receive adult health care because of issues related to insurance and resources. Neighborhood resources are not as available to provide adequate care for low-income minority youth, leading to healthcare disparities. Some studies report that minority youth are more distrustful than nonminority youth of healthcare providers, which adds to the difficulties of transferring from pediatric to adult health care (Lotstein et al., 2010).

Compared with other racial or ethnic groups of youth transitioning into adulthood, American Indian and Alaska Native youth are reportedly worse off in several areas, including “widespread poverty, poor health, overcrowded housing...high teen birth rates, low educational achievement, and high rates of foster care” (Fox, Becker-Green, Gault, & Simmons, 2005, p. 6). A review of tribal youth ages 16–24 found that these youths are “anxious to become

responsible adults and role models in their communities” but “are confused as to how to proceed” (Fox et al., 2005, p. 9). The review highlights the need to create programs unique to tribal youth.

Additional studies on racial and ethnic minority transition-age youth suggest that differences within cultural subgroups, as well as between racial and ethnic groups, should be considered in the creation of effective prevention and treatment programs for transition-age youth and their families (Cook, Karriker-Jaffe, Bond, & Lui, 2015; Manlove, Steward-Streng, Peterson, Scott, & Wildsmith, 2013).

Initiatives and Programs to Support Transition-Age Youth

The service needs of transition-age youth are unique, different from the needs of adolescents and adults (Manteuffel et al., 2008). Ideally, such services are flexible, informal, and individualized toward the maturing young person – yet involve both the youth and family in planning. A number of initiatives and programs have been implemented to address the needs of this population.

In 1992, the U.S. Congress established the Children’s Mental Health Initiative within SAMSHA to fund systems-of-care services in communities nationwide (Stroul, Goldman, Pires, & Manteuffel, 2012). First introduced in the 1980s to address the “serious and complex mental health needs of children involved with multiple child-serving systems” (Stroul et al., 2012, p. 1), a systems-of-care approach involves a comprehensive and coordinated network of services and supports informed by the core values of providing services that are community-based, child-centered, family-focused, and culturally appropriate (Huang et al., 2005). Although the initiative supported systems-of-care for youth from birth to age 22, few programs as of 2008 focused on people over age 18, and most adolescent-based services initially targeted youth ages 14–17 (Manteuffel et al., 2008).

To meet the needs of older, high-risk youth, SAMSHA (2009a) established funding for the Healthy Transitions Initiative, a cooperative state/community partnership agreement for integrating supports and services for transition-age youth, ages 16–25. The initiative’s goal was to “create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for youth and young adults with serious mental health conditions” (p. 1). The initiative focused on “education, employment, housing, mental health and co-occurring disorders, and decreased contacts with the juvenile and criminal justice system” (p. 1). Initially, seven states (Georgia, Maine, Maryland, Missouri, Oklahoma, Utah, and Wisconsin) were awarded funds to implement models of service delivery.

In this initiative, special attention also was directed toward the development of a youth-oriented recovery model of care for adolescents and transition-age youth with substance use or co-occurring mental health and substance use disorders (SAMHSA, 2009b). Using the systems-of-care approach, the recovery model aspired to “build bridges between the substance abuse and mental health fields” (SAMHSA, 2009b, p. i) to improve integration of care for transition-age youth. According to SAMHSA (2009b), a recovery-oriented system of care focuses on “engendering hope, optimism, and maximizing each young person’s full potential” and aims to

create programs that are “family- and youth-driven, culturally and linguistically competent, evidence-informed, strengths-based, and integrated” (p. 40).

Based on the recovery model of care, SAMSHA (2014b) recently created a new grant program to fund programs specifically for transition-age youth at high risk for developing a serious mental health condition, substance use or co-occurring disorders, or suicidal behavior.

Screening, prevention, and intervention services are linked and often overlap in systems of care designed for transition-age youth.

Screening

Screening within schools, mental health, child welfare, juvenile justice, physical health and substance use centers, outpatient treatment, and in-patient hospitals lead to the majority of referrals for services (Manteuffel et al., 2008). Initial screening of people who present for services suggest that alcohol or substance use are more common problems for 16- and 17-year-olds than 14- and 15-year-olds (Manteuffel et al., 2008). Outreach and engagement strategies, peer-to-peer and family supports, and social media are examples of techniques that serve the purpose of screening and prevention.

Prevention

Some programs customize their services to address potential problems to prevent decline in the functioning of youth as they transition to adulthood. Such services include suicide prevention programs, which provide general education and awareness of suicide behavior to youth and caregivers (Rodgers, Sudak, Silverman, & Litts, 2007). Financial and housing services enable youth to function independently (Manteuffel et al., 2008).

Intervention

Interventions in systems of care include family preservation services, medication treatment and monitoring, individual and family therapy, case management and independent living services, transition services, recreational services, and respite services. In a study (Manteuffel et al., 2008) of transition-age youth in 45 federal systems, 14- and 15-year-olds were most likely to receive clinical and support services attuned to their living situation (for example, family therapy, respite, and recreational services) and 16- and 17-year-olds tended to receive case management, medication treatment and monitoring, and family preservation in the first 6 months of care, followed by transition and independent living services thereafter. Older youth were less likely to receive clinical services through individual or family therapy.

Supported employment is one example of a service that meets the dual goals of prevention and intervention, targeted specifically toward the developmental needs and interests of the emerging adult with severe mental illness. It helps “transition-age youth and young adults to obtain employment and develop meaningful careers and financial security” (Burke-Miller, Razzano, Grey, Blyler, & Cook, 2012, p. 171). Because “work and return to work are ongoing challenges in the lives of people in recovery” (p. 178), supported employment interventions “emphasize a recovery focus, as well as evidence-based principles of best practices in vocational rehabilitation” (p. 177).

Additional interventions include the involvement of mentors, peer supports, and the person receiving the services. Services often are delivered using a wraparound practice model, a process by which a team and care manager coordinate formal and informal services selected by the young person (Koroloff, Walker, & White, n.d.). Some communities providing wraparound services for youth have appointed SE specialists on the local teams. To strengthen communication and engagement, some states now allow staff to use smart phones to text with young adults. Other states and communities encourage youth involvement by having them lead meetings and direct their own planning teams. “Integral to this practice change is that staff are trained to solicit and use youth input” (Koroloff et al., p. 3).

Evidence of Program Impact

Evidence of the effectiveness of programs created for transition-age youth is sparse. Reportedly, people ages 16–21 who received services through SAMHSA-funded programs between 2002 and 2009 demonstrated “marked improvement” (SAMHSA, 2013, p. 2). Specifically, Children’s Mental Health Initiative participants showed 38 percent significant improvement in their emotional and behavioral health within the first year; after 6 months of care, homelessness decreased by 36 percent for youth 18 and older. Youth reported “greater confidence in their abilities to perform important life skills such as preparing meals and securing rental agreements” (p. 2). Participants in the Emerging Adults Initiative after 6 months reported a 37 percent increase in positive functioning, a 30 percent increase in having a stable place to stay, and a 10 percent increase in employment or school enrollment. Outcomes from substance use treatment programs reported an 80 percent increase in young adults living in the community, 34 percent decrease in mental health concerns, and a 10 percent increase in work or school enrollment. However, this study had no comparison group, so the positive outcomes may or may not be attributable to the services received.

Several programs funded by “Now is the Time” grants were evaluated using more rigorous research designs and found positive overall outcomes. However, most programs are not designed specifically for transition-age youth. For instance, twelve-step facilitation therapy is a brief, structured, manualized approach to aid the early recovery from alcohol, drug abuse, and addiction problems. The therapy is widely used in all 50 states, has been evaluated through comparative effectiveness research studies and shows significant positive outcomes compared with treatment-as-usual. However, the therapy is designed for adults, ages 18–55, and no known studies focus on its effectiveness for transition-age youth.

Similarly, two additional programs reviewed by the National Registry of Evidence-based Programs and Practices and funded through Now Is the Time include transition-age youth: 1) reinforcement-based therapeutic workplace (RBTW), which is a substance use treatment that involves voucher-based abstinence reinforcement therapy for people who abuse cocaine, and 2) coordinated anxiety learning and management (CALM), which is a therapy aimed at reducing symptoms of anxiety and depression and improving participant functioning. Randomized clinical trials found RBTW to be effective as a long-term maintenance intervention for cocaine dependence and CALM to be effective in decreasing the symptoms of depression and anxiety

(SAMSHA, 2015). However, no studies have specifically evaluated the effectiveness of these programs for people ages 18–26.

Evaluations of Family Spirit—a family strengthening home-visiting program for American Indian mothers ages 13–25—are encouraging. Family Spirit is designed to increase the mothers’ parenting knowledge and competence, reduce the behavioral and psychosocial risks that interfere with their parenting, and promote the healthy development of their infants and toddlers. Three randomized clinical trials found that mothers who participated in the program, compared with mothers in control groups, had significantly higher child care knowledge and involvement with their children (Barlow et al., 2006); increased maternal knowledge and lower externalizing infant behavior outcomes (Walkup et al., 2009); and improved parenting and infant outcomes linked to the prediction of a lower lifetime risk for behavioral and drug use (Barlow et al., 2013).

In addition to meeting direct health care and psychosocial needs of transition-age youth, a central aim of initiatives for emerging adults is to create intentional system change at the community and state level. Walker and colleagues (2015) concluded, “service change at the program or agency level is not sustainable without related changes at the systems or policy level” (p. 254). Currently, researchers are developing, adapting, and testing assessment measures (e.g., the Community Support for Transition Inventory and the State Support for Transition Inventory) that examine systems change in states that have received the Healthy Transitions grants. Pilot testing of the instruments suggest they can provide reliable feedback on change at the community and state level to implement coordinated and comprehensive services.

Potential Role of Protective Factors

Researchers agree that negotiating the developmental tasks of emerging adulthood is more complicated for youth who receive care from public or private systems than for youth without such care needs (Berzin, 2010). For some young people with special needs, involvement in a healthcare system exacerbates their risks, and “layered dimensions of risk may intensify their difficulties during emerging adulthood” (p. 488). The presence of multiple risk factors can make even more challenging a transition into adulthood, and “subsets of youth may remain particularly vulnerable, while others may adapt successfully” (p. 488).

Researchers have yet to provide sufficient clarity about how pre-existing risk factors (such as race, ethnicity, social class, health) interconnect to influence vulnerability or create resilience (Berzin, 2010). This clarity could help anticipate the complications that arise from the interactions among the individual characteristics of transition-age youth, such as personality traits and positive or negative family relationships; the psychosocial challenges youth face, such as poverty; and the systems of care the community and state provide. Furthermore, a better understanding of how race, ethnicity, and social class are often confounded, could guide the development of appropriate services and the assessment of service outcomes.

While there is much still to be learned, research has indicated the potential positive impact of various protective factors. One known significant factor that influences resiliency is the

ongoing development of the prefrontal cortex of the brain during this transitional period. Development of executive functioning, working memory, and inhibitory control continues into the mid-20s and affects the young person's cognitive flexibility and capacity for appropriate decision-making (Burt & Paysnick, 2012). Another protective factor is the presence of positive relationships and mentors, regardless of socioeconomic class. Longitudinal studies of transition-age youth underscore the "general importance of *relationships* in the functioning of individuals judged resilient in young adulthood" (p. 498).

Together, these factors suggest the need to provide services for young people that are flexible, build on their developing cognitive strengths and executive functioning, and encourage peer-to-peer support and mentor-to-peer relationships. Such services highlight the young person's self-efficacy, budding opportunities, and emerging capacities, even when high levels of adversity otherwise characterize the youth's environment.

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References

- Administration for Children & Families (2015). *Child welfare policy manual, June 22, 2015*. Washington, DC: U.S. Department of Health & Human Services.
- Administration for Children & Families (2012). *The AFCARS report, FY 2011*. Adoption and Foster Care Analysis and Reporting System (AFCARS). Washington, DC: U.S. Department of Health & Human Services.
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55*(5), 469–480.
- Arnett, J. J. (2003). Conceptions of the transition to adulthood among emerging adults in American ethnic groups. *New Directions for Child and Adolescent, 100*, 63–75.
- Arnett, J. J. (2014). Personal address: The emergence of emerging adulthood: A personal history. *Emerging Adulthood, 2*(3), 155–162.
- Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., ...Walkup, J. T. (2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. *American Journal of Psychiatry, 170*(1), 83–93.
- Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., ...Walkup, J. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Archives of Pediatrics & Adolescent Medicine, 160*(11), 1101–1107.
- Berzin, S. C. (2010). Vulnerability in the transition to adulthood: Defining risk based on youth profiles. *Children and Youth Services Review, 32*, 487–495.
- Berzin, S. C., & De Marco, A. (2010). Understanding the impact of poverty on critical events in emerging adulthood. *Youth & Society, 42*(2), 278–300.
- Burt, K., & Paysnick, A. (2012). Resilience in the transition to adulthood. *Development and Psychopathology, 24*, 493–505.
- Burke-Miller, J., Razzano, L., Grey, D., Blyler, C., & Cook, J. (2012). Supported employment outcomes for transition-age youth and young adults. *Psychiatric Rehabilitation Journal, 35*(3), 171–179.
- Copeland, W., Angold, A., Shanahan, L., & Costello, J. (2014). Longitudinal patterns of anxiety from childhood to adulthood: The Great Smoky Mountains Study. *Journal of American Academy of Child and Adolescent Psychiatry, 53*(1), 21–33.
- Cook, W. K., Karriker-Jaffe, K., Bond, J., & Lui, C. (2015). Asian American problem drinking trajectories during the transition to adulthood: Ethnic drinking cultures and neighborhood contexts. *American Journal of Public Health, 105*(5), 1020–1027.
- Fox, K., Becker-Green, J., Gault, J., & Simmons, D. (2005). *Native American youth in transition: The path from adolescent to adulthood in two Native American communities*. Portland, OR: National Indian Child Welfare Association.
- Hammond, W. P. (2012). Taking it like a man: Masculine role norms as moderators of the racial discrimination – depressive symptoms association among African American men. *American Journal of Public Health, 102*, 232–241.
- Hardaway, C., & Mcloyd, V. (2009). Escaping poverty and securing middle class status: How race and socioeconomic status shape mobility prospects for African Americans during the transition to adulthood. *Journal of Youth Adolescence, 38*(2), 242–256.

- Heflinger, C., & Hoffman, C. (2006). Transition-age youth in publicly funded systems: Identifying high-risk youth for policy planning and improved service delivery. *Journal of Behavioral Health Services & Research*, 35(4), 390–401.
- Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S. & Mayberg, S. (2005). Transforming mental health care for children and their families. *American Psychologist*, 60(6), 615–627.
- Insel, T. (2015, May 15). *Director's blog: Mental health awareness month: By the numbers*. Washington, DC: National Institute of Mental Health.
- Johnson, K.D., Whitbeck, L.B., & Hoyt, D. R. (2005). Predictors of social network composition among homeless and runaway adolescents. *Journal of Adolescence*, 28, 231–248.
- Koroloff, N., Walker, J., & White, G. (n.d.). *Happy Transitions Initiative issue brief 1: Impact at the local community level*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University of Child and Human Development.
- Lotstein, D., Kuo, A., Strickland, B., & Tait, F. (2010). The transition to adult health care for youth with special health care needs: Do racial and ethnic disparities exist? *Pediatrics*, 126(3), 129–136.
- Manlove, J., Steward-Streng, N., Peterson, K., Scott, M., & Wildsmith, E. (2013). Racial and ethnic differences in the transition to a teenage birth in the United States. *Perspectives on Sexual and Reproductive Health*, 35(2), 89–100.
- Manteuffel, B., Stephens, R., Sondheimer, D., & Fisher, S. (2008). Characteristics, service experiencers, and outcomes of transition-aged youth in systems of care: Programmatic and policy implications. *Journal of Behavioral Health Services & Research*, 35(4), 469–487.
- Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, 52(5), 597–599.
- McGorry, P. (2011). Transition to adulthood: The critical period for pre-emptive, disease-modifying care for schizophrenia and related disorders. *Schizophrenia Bulletin*, 37(3), 524–530.
- Now Is the Time: The President's plan to protect our children and our communities by reducing gun violence. 2013. Retrieved from https://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf
- Pecora, P., Jensen, P., Romanelli, L., Jackson, L., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare*, 88(1), 5–26.
- Rodgers, P., Sudak, H., Silverman, M., & Litts, D. (2007). Evidence-based practices project for suicide prevention. *Suicide & Life-Threatening Behavior*, 27(2), 154–164.
- Salazar, A., Keller, T., Gowen, L. K., Courtney, M. (2013). Trauma exposure and PTSD among older adolescents in foster care. *Social Psychiatry Psychiatric Epidemiology*, 48(4), 545–551.
- SAMSHA (2009a). Cooperative agreements for state/community partnerships to integrate services and supports for youth and young adults 16–25 with serious mental health conditions, and their families (Healthy Transitions Initiative). RFA No. SM-09-008. CDFA No. 93.243. Rockville, MD: U.S. Department of Health and Human Services.
- SAMHSA (2009b). Designing a recovery-oriented care model for adolescents and transition-age youth with substance use or co-occurring mental health disorders. Rockville, MD: U.S. Department of Health and Human Services.

- SAMHSA (2013). Promoting recovery and independence for older adolescents and young adults who experience serious mental health challenges. National Children's Mental Health Awareness Day – May 9, 2013. Rockville, MD: U.S. Department of Health and Human Services.
- SAMHSA (2014a). The CBHSQ report: Serious mental health challenges among older adolescents and young adults. Rockville, MD: U.S. Department of Health and Human Services.
- SAMHSA (2014b). "Now is the time" health transitions (HT): Improving life trajectories for youth and young adults with, or at risk for, serious mental health conditions. RFA No. SM-14-017. Rockville, MD: U.S. Department of Health and Human Services.
- SAMHSA (2015). *National registry of evidence-based programs and practices*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=358>
- Sheidow, A., McCart, M., Zajac, K., & Davis, M. (2012). Prevalence and impact of substance use among emerging adults with serious mental health conditions. *Psychiatric Rehabilitation Journal*, 35(3), 235–243.
- Silva, J. (2012). Constructing adulthood in an age of uncertainty. *American Sociological Association*, 77(4), 505–522.
- Stroul, B., Goldman, S., Pires, S., & Manteuffel, B. (2012). *Expanding systems of care: Improving the lives of children, youth, and families*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
- Syed, M., & Mitchell, L. (2013). Race, ethnicity, and emerging adulthood: Retrospect and prospects. *Emerging Adulthood*, 1(2), 83–95.
- Uhlhaas, P. (2011). The adolescent brain: Implications for understanding, pathophysiology, and treatment of schizophrenia. *Schizophrenia Bulletin*, 37(3), 480–483.
- Walker, J., Koroloff, N., & Mehess, S. (2015). Community and state systems change associated with the Healthy Transitions Initiative. *Journal of Behavioral Health Services & Research*, 42(2), 254–271.
- Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R....Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 591–601.
- Wenzel, S., Holloway, I., Golinelli, D., Ewing, B., Bowman, R., & Tucker, J. (2012). Social networks of homeless youth in emerging adulthood. *Journal of Youth Adolescence*, 41, 561–571.
- Williams, A., & Sheehan, R. (2015). Emerging adulthood in time and space: The geographic context of homelessness. *Journal of Family Theory & Review*, 7, 126–143.
- Yates, T., & Grey, I. (2012). Adapting to aging out: Profiles of risk and resilience among emancipated foster youth. *Development and Psychopathology*, 24, 475–492.

Suggested Reference: SAMHSA's National Registry of Evidence-based Programs and Practices. 2017. *Behavioral Health Services for Transition-Age Youth. Evidence Summary*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from [\[insert hyperlink\]](#)