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Supporting Connections: A Focus on the Mental Health Needs and Best Practices for Youth in Out-of-Home Care Transitioning to Adulthood

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Key Points

- Youth transitioning out of the child welfare system to independence face numerous obstacles and challenges placing them at risk for poor outcomes.
- Understanding federal and state policies around transitional age youth in the child welfare system can help you as the provider advocated for appropriate services and supports to promote resilience.
- Examples of best practices for providers working with child welfare-involved young adults are outlined below.

Introduction

The transition to adulthood from adolescence is challenging for many young people but especially difficult for child welfare-involved youth. For all youth, this developmental period requires attainment of multiple developmental milestones in the areas of self-sufficiency as well as adjusting to new environments and responsibilities such as parenting, working, or continuing education [1]. In the United States, the transition from adolescence to young adulthood is an increasingly lengthy and complicated process with recent transitional age youth facing more challenges than previous generations [2]. Many transitional age youth benefit from emotional, pragmatic, and financial support from their parents and kin, but foster youth do not typically enjoy these types of family support [3]. Furthermore, many foster youth experience adverse events that increase risk for problematic emancipation, including neglect, abuse, trauma, disrupted attachments, unstable housing, multiple placements, fragmented schooling, disrupted social networks, poverty, and gestational exposures. These realities increase the risk that foster care alumni will experience negative functional outcomes, including lower education attainment, unemployment, poverty, homelessness, food insecurity, mental health and substance use chal-

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lenges, health problems, early pregnancy and parenthood, and involvement with the justice system. The term "transitional age youth" originates from child welfare, following advocacy by stakeholders to provide developmentally appropriate services to support youth exiting foster care by "aging out" or meeting the legal age of adulthood and subsequently losing child welfare services [4]. With this focus on aging out youth, legislation, research, and grants have led to improvements to a system of care to meet the needs of this vulnerable population, but challenges continue.

Child Welfare System

The child welfare system emerged in the 1970s through advocacy from the pediatrics community following Dr. Henry Kempe's seminal article on child abuse, "The Battered Child Syndrome" [5]. Over the past 60 years, the child welfare system has evolved from a culture purely looking to ensure safety from abuse and neglect to one that considers the whole child. The federal 1997 Adoption and Safe Families Act outlined the three goals for the current national child welfare system: safety, permanency, and well-being. The term well-being assesses a child's development within four domains: cognitive functioning, physical health and development, emotional/behavioral functioning, and social functioning [6]. Permanency is a concept based on the value that youth grow up best in a family environment that is committed, long-lasting, nurturing, and stable. Permanency may be achieved by such pathways as reunification, adoption, or legal guardianship. Despite child welfare agencies' mandates and efforts to establish permanent homes for youth in foster care, some youth emancipate or "age out" from foster care when they turn 18 or 21 years old, or achieve a high school diploma. By definition, youth who age out of foster care did not achieve permanency [7].

Youth enter the child welfare system most often following concerns for child maltreatment. National data reporting of child maltreatment indicates that just under 700,000 youth are substantiated maltreatment victims each year, with a rate of 9.1 victims per 1000 children. The most common types of child maltreatment reported are neglect (74.9%) and physical abuse (18.3%), and youth may experience multiple types of abuse. In 2017, deaths from child maltreatment were estimated to be 1720 [8] (Fig. 22.1).

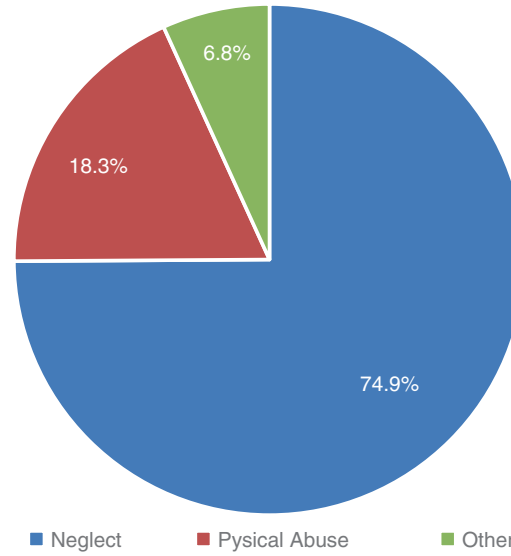

Fig. 22.1 Types of reported child maltreatment in the United States by percentage. (Adapted from US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. Child maltreatment 2017. https://www.acf.hss.gov/cb/research-data-technology/statistics-research/child-meltreatment 2019)

Nationally there are over 400,000 youth in foster care which is a 10% decrease over the last 10 years [9]. The average length of time for a youth in care is 19 months. Most youth are placed in a non-relative foster home (45% of youth), but efforts are made by agencies to place youth with relative foster families (32%). There is a national trend away from institutional care with just 13% of youth residing in congregate care (Fig. 22.2).

The most common path to exit out-of-home care is through reunification at 49%, with adoption as the second most common path at 24% [10]. Permanency becomes more difficult to achieve with older foster children, with rates of adoption decreasing in older adolescents to just 3% [11]. Most adolescents who are in the foster

care entered as adolescents, and youth who enter the foster care system after 12 years of age are less likely to find a permanent home compared to general foster care populations [9]. While the overall numbers of youth entering the child welfare system have overall declined in the past 10 years, there has been a significant increase in the number of youth "aging out" of foster care without finding a permanent home [12]. In fact, the percentage of older youth achieving permanency has not changed in the past decade [13].

About 20,000 of foster youth age out of services annually, most at age 18 years [11]. Recent changes to federal law allow states to provide foster care to youth up to age 21 years, also known as Extended Foster Care, and claim federal reimbursement. Among all foster youth, 28% are between the ages of 12 and 17 years and 4% between 18 and 20 years old [10] (Fig. 22.3).

African American and Native American youth are disproportionately represented in the child welfare system with rates of representation in the child welfare system at 17.4 and 14.1 per 1000 youth, respectively, compared to 5.8 for Hispanic, 4.6 for White youth, and 1.3 for Asian youth [14, 15] (Fig. 22.4).

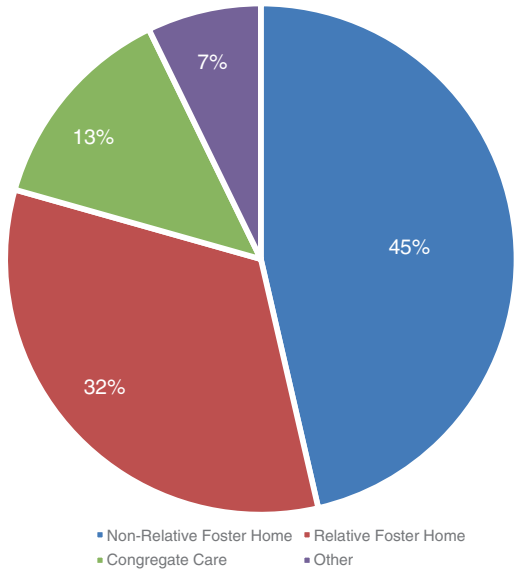

Fig. 22.2 Out-of-home placement types by percentage. (Adapted from US Department of Health and Human Services, Administration for Children and Families, Administration on Children Y, and Families, Children's Bureau. The AFCARS Report FY 2017. https://www.acf.hhs.gov/cb/resource/afcars-report-25; 2018.ge)

Legislation Impacting Transition-Age Foster Youth

Key legislation targeting older foster youth began in the late 1990s. One of the most important pieces of federal legislation supporting this population is the 1999 Foster Care Independence Act. This Act provides federal funding for independent living and transition services for older youth. The Act also created a reporting system called the National Youth in Transition Database which surveys youth between the ages of 18 and 21 years

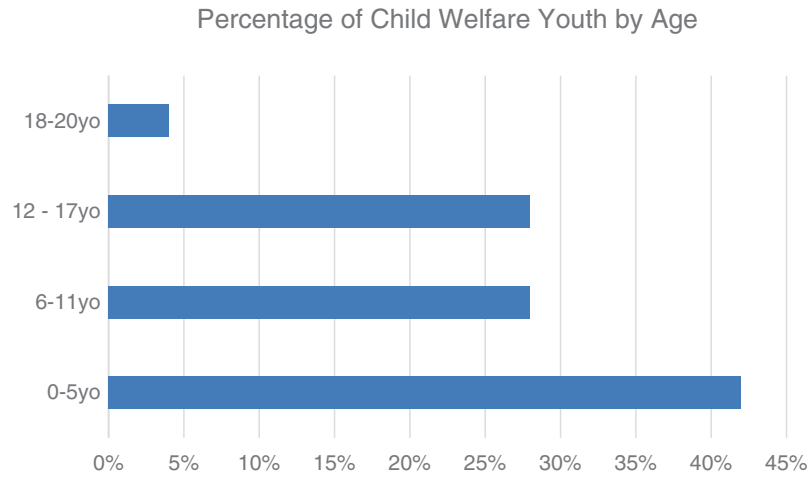

Fig. 22.3 Age of children in child welfare, by percent. (Adapted from US Department of Health and Human Services, Administration for Children and Families, Administration on Children Y, and Families, Children's Bureau. The AFCARS Report FY 2017. https://www.acf.hhs.gov/cb/resource/afcars-report-25; 2018)

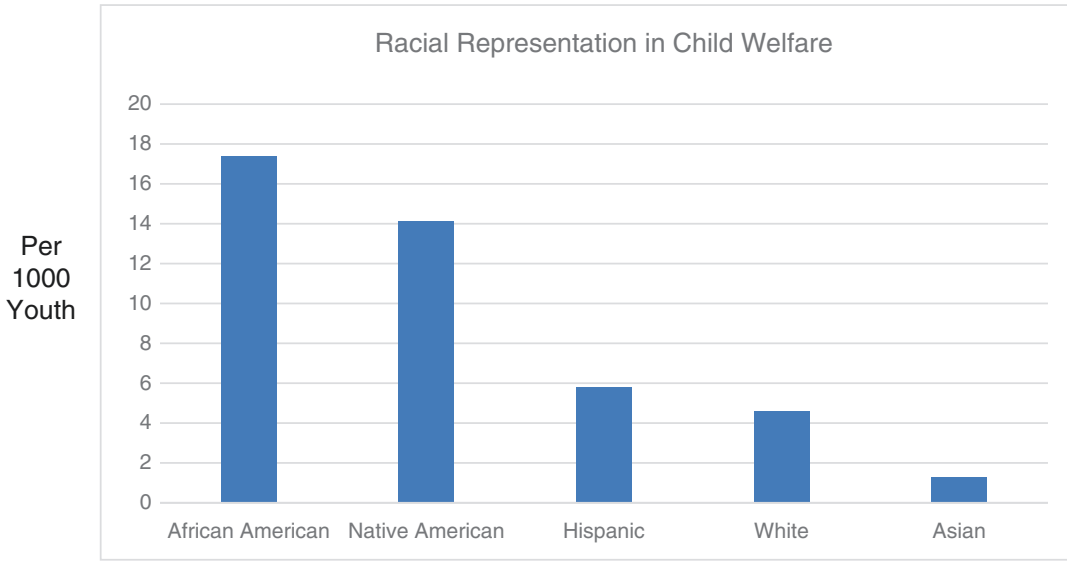

Fig. 22.4 Racial/ethnic representation in child welfare. (Adapted from US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. Data brief 2013-1: recent demographic trends in foster care. https://www.acf.hhs.gov/sites/default/files/cb/data_brief_foster_care_trends1.pdf; 2013)

old. This legislation was followed by the 2001 Education and Training Voucher Program which provides federal funds for postsecondary education or vocational programs for foster youth. In 2008, the Fostering Connections to Success and Increasing Adoptions Act provided voluntary Extended Foster Care (EFC) beyond age 18 years, up to age 21 years. The policy aimed to allow young people more time to prepare for adulthood with the support from the child welfare system [13]. This group of legislation establishes several services and practices to facilitate foster youth transition to adulthood.

Federal legislation outlined above sets forth requirements for youth who leave foster care due to age restrictions. A transition plan must be developed 90 days before discharge from foster care. The transition plan must be youth-directed and must address housing, health insurance, education, opportunities for mentoring and continuing support services, and workforce supports and employment services. Federal legislation requires states to develop oversight practices and coordination of health care, including behavioral health, and encourages mechanisms for ensuring continuity of care and transition to adult healthcare systems. Federal legislation offers funding to states to help with education, employment, financial literacy, housing, life skills training, transition services, emotional support, and encouraging relationships with caring adults. The federal requirement for transitioning planning at 90 days is the minimum time frame, and best practices encourage exploring and preparing for transition planning up to a year before [16].

Transition plan requirements can vary from state to state, but the Preventing Sex Trafficking and Strengthening Families Act requires specific components. When a youth is aging out of a state child welfare system, the state is federally required to provide the youth with the following: birth certificate, Social Security card, health insurance information, medical records, and a driver's license or state-issued identification card. This Act also requires case plans to offer transitional services starting at age 16 years with youth involvement in planning. The Affordable Care Act extends Medicaid eligibility to foster care alumni who aged out of care, up to age 26 years. To be eligible, the youth must have been enrolled in Medicaid while in foster care and reside in the state where either they were in foster care or have

moved to 1 of the 11 states that will cover foster care alumni from other states [16]. The following website lists state Medicaid plans that will and will not cover foster alumni from another state: http://healthcareffy.org/.

The Education and Training Voucher Program is a federal program providing financial assistance (currently up to $5000/year) to foster youth and alumni enrolled in college, university, vocational, or technical training programs. Youth must enroll before their 21st birthday and remain eligible until age 23 years. Some states provide additional financial assistance for foster or former foster youth postsecondary education.

States have the option to provide developmentally modified foster care services with Extended Foster Care to foster youth up to age 21 years. To qualify for EFC, youth must be in an education or training program; working; in a program to address barriers to schooling, training, or work; or suffering a disability that prevents schooling or work. Being in Extended Foster Care has shown to help youth transition from foster care to adulthood. Youth who received Extended Foster Care are more likely at ages 19 and 21 years to be employed, enrolled in school, receive educational aid, avoid homelessness, avoid disconnection from work or school, and delay parenthood [13]. To avoid disincentives to permanency, EFC, independent living programs, and education and training supports can also be made available to youth exiting foster care through guardianship at age 16 years or older.

The 2018 Family First Prevention Services Act significantly changes the landscape of child welfare funding to support children to remain safe at home and encourage family-based placement when foster care is necessary. The other key priority of this legislation is to strengthen services for older youth. Family First allows federal funding to support older youth to live in family settings, safely care for their own children if pregnant or parenting, and expands access to independent living services. The Act also supports efforts to prevent older children from coming into care [17]. Family First also makes changes in the 1999 Chafee program to give states the flexibility to extend the Chafee program from age 21 up to age 23 years in states opting to provide EFC [16].

Overview of Foster Care Alumni Studies

The Northwest and Midwest studies are among the first series of reports that looked closely at what happens to foster care youth who age out of the child welfare system ("foster care alumni"). These reports help shed light on some of the significant challenges these youth are up against and look at ways foster services could improve their lives. These studies catalyzed change driving state and federal funding as well as program development to better serve the needs of this vulnerable population.

The Northwest Foster Care Alumni Study reviewed the cases of 659 alumni, of which 479 were interviewed, who were in the care of Casey Family Programs or in Oregon or Washington state child welfare agencies between 1988 and 1998. Youth were between the ages 20 and 33 years. The study outlined three key domains within this population: mental health, education, and employment and finances. Regarding mental health, compared to the general population, foster care alumni suffered a higher rate of mental health disorders. Within the 12 months prior to being interviewed, 54.4% of participants reported one or more mental health disorders. PTSD rates were double that of US war veterans at 25.2%, and alumni also reported major depression at 20.1% and social phobia at 17.1%. Studies in the second domain of education found alumni completed high school at a similar rate to the general population, but alumni used GED programs at six times the rate of the general population. The report also shed light on the instability in school placements with 65% of participants reported experiencing seven or more school changes in elementary through high school. The difficulty obtaining higher education was also noted with less than 3% of participants completing a bachelor's degree. The final domain of employment and finances also noted disparities compared to the general population, finding that 33% of

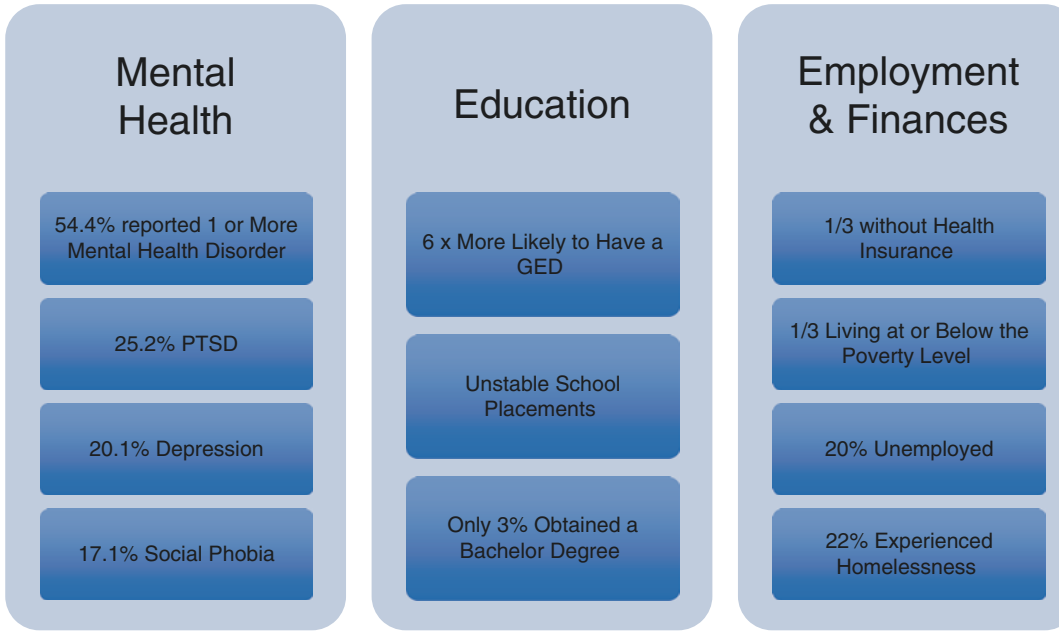

Fig. 22.5 Three outcome domains of the Northwest Foster Care Alumni Study. (Adapted from Pecora et al. [18])

alumni had no healthcare insurance, 33.2% had household incomes at or below the poverty level, and only 80.1% were employed of those eligible to work. Difficulties with stable housing were also seen with 22.2% reporting homelessness for one or more days after age 18 years [18] (Fig. 22.5).

The Midwest Study was undertaken to develop a more comprehensive view of foster youth transitioning to adulthood following a shift in federal funding (1999 Chafee Act) to support older youth in foster care. This has been the largest longitudinal study of youth aging out of foster care. Youth from Illinois, Iowa, and Wisconsin were followed from age 17 through 26 years, with five waves of data collection [3]. This study further investigated the disparities brought to light in the Northwest Study. In the domain of education, former foster youth by age 26 years were three times more likely than same peers to not have a high school diploma or GED (20% vs. 6%), while same-age peers were six times more likely to have a postsecondary degree (46% vs. 8%) and nine times more likely to have a 4-year college degree (36% vs. 4%). At age 26 years, female foster care alumni were seven to ten times more likely to have been arrested (41% vs. 5%), convicted (22% vs. 3%), and incarcerated (33% vs. 3%) since age 18 years, while male foster care alumni reported three- to eightfold increases (68% vs. 22%, 47% vs. 11%, and 64% vs. 9%, respectively). Nearly 80% of the women had at least one pregnancy by age 26 years. Financial disparities were also highlighted, with nearly 70% of women and 40% of men reporting using government assistance to access food in the last year, and of the 70% who reported earning an income, half earned $9000 or less annually, indicating concerns for poverty [3] (Fig. 22.6).

The Midwest Study also examined the effects of Extended Foster Care. At the time of the study, Illinois offered foster care up to age 21 years, while Iowa and Wisconsin terminated foster care at age 18 years. At age 19 years old, youth in Wisconsin and Iowa were 2.7 times more likely to be homeless than foster youth in Illinois, and youth remaining in foster care were at least twice as likely to complete at least 1 year of college by age 21 years [19]. Courtney et al. (2009) estimated that each dollar spent on EFC returned $2.40 in increased income, based on anticipated higher college graduation rates [20].

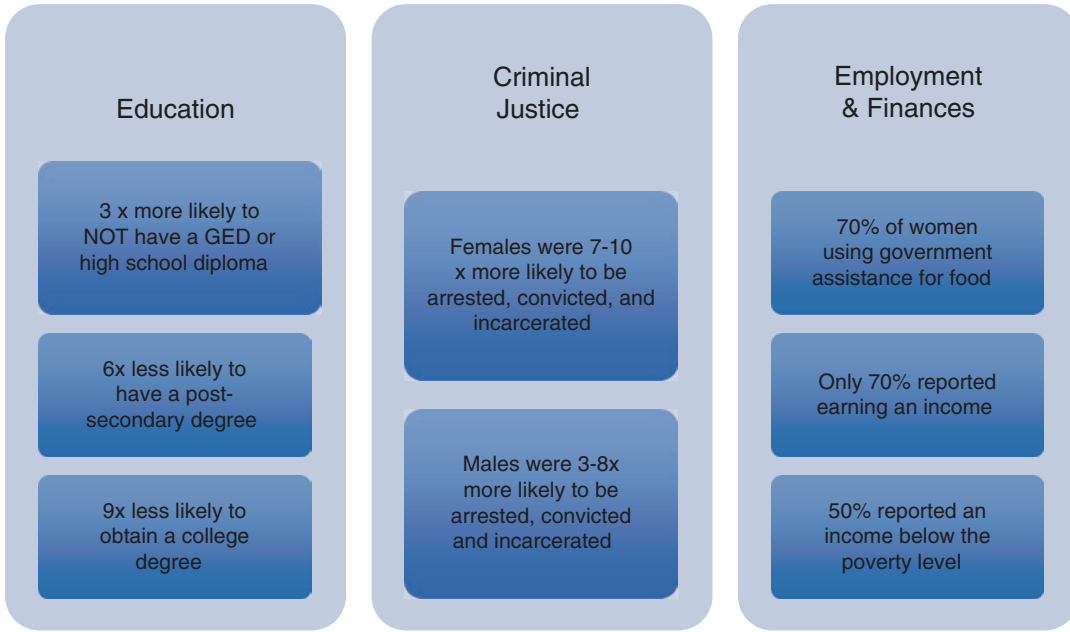

Fig. 22.6 The Midwest Study outcome domains for foster care alumni. (Adapted from Courtney et al. [3])

Transition Health Care (THC): Pediatrics to Adult Care

Reaching the age of majority, transitioning foster youth are expected to manage their own health care, and many may not be eligible to receive the number of supports that they were accustomed to while in state custody. Also, those with intellectual and/or developmental disabilities (e.g., Down's syndrome, autism) will need continued support in order to navigate transportation to appointments and assistance in understanding of the treatment that they are receiving. Many adult providers are not comfortable treating chronic childhood illnesses, and pediatricians do not have the resources to continue treating young adult patients. Pediatricians have difficulty finding adult providers who feel adequately trained in adolescent medicine, adolescent development, or adolescent behavior to take on these cases. Peter et al. (2009) surveyed internists who expressed the following identified concerns that clustered into six major themes: family involvement, patient maturity, systems issues, providers' medical competency, patient psychosocial needs, and coordination of the transition process. Health insurance is another obstacle facing young adults transitioning from foster care. Both the Midwest and Northwest studies reported that roughly 51–53%, respectively, of foster youth had no health insurance at the time of exiting foster care, which is double the rate for young adults in the general population..

Mental Health Considerations for Transition-Age Foster Youth

According to the NIMH, in 2017, young adults aged 18–25 years had the highest prevalence of serious mental illness (SMI) (7.5%) compared to adults aged 26–49 years (5.6%) and aged 50 years and older (2.7%). Former foster youth with mental illness often have past trauma histories that make it challenging for them to develop and maintain healthy adult relationships. Many will experience mistrust to new healthcare systems and providers, and their mood may easily become dysregulated as a result of insecure attachments [21]. Some researchers have shown that the more

placements a child experiences, the higher the risk of attachment issues which can lead to a high risk of psychiatric morbidity in adulthood [22]. Evidence that can explain health differences between former foster youth as compared to other vulnerable young adults without foster care experience is limited. One systematic review of literature found no studies that included a sample of youth who were both homeless and had been in foster care, despite the overlapping needs of these youth in transition [23]. Supplemental studies regarding the impact of social capital on health outcomes for former foster youth as compared to non-foster peers with similar vulnerabilities, such as poverty, are warranted [24]. Also, there have been studies linking child abuse histories to mental health problems in adulthood, but not much research has looked at the effects of maltreatment while in foster care related to adult mental health [22]. Further, transitional age youth with untreated mental health disorders are at high risk for substance abuse, physical assault, and encounters with the correctional system [25]. Other studies have shown that being a victim of child abuse and neglect is commonly associated with depression, PTSD, substance use, and antisocial behaviors [26]. Entering the foster care system has been associated with a high risk of behavioral and mental health needs [27], and older youth consume more behavioral healthcare services than those of same-age peers not in foster care [28–30]. However, the use of services drops to approximately 50% when these older youth exit foster care between ages 18 and 21 years [31]. For unclear reasons, this drop may be accounted for by poor coordination between pediatric and adult providers, youth's choices in taking charge of their own care, or difficulty accessing adult services.

The Midwest Study described that the peak prevalence of alcohol abuse/dependence and other drug abuse/dependence increases from ages 19 to 26 years whereas the prevalence of non-foster youth peaks at ages 19–21 years, which decreases over time [3, 32]. Another study found that 45% of 17-year-olds in state custody, within a year of leaving care, used alcohol or illicit drugs in the last 6 months, 49% had tried one time in their lifetime, and 35% met criteria for substance use disorder [33]. Also having a diagnosis of PTSD and conduct disorder (CD) increased the chances of high rates of use and a substance use disorder. Vaughn also found that those with SUD used higher amounts than their non- foster peers and warns that those youth are at a higher risk of overdoses. White et al. (2008) found that foster alumni had higher rates of substance use and dependence than the general population, but the rates were lower in those youth who reported a constant support of a foster family [34, 35].

Psychotropic Medications

A large national probability sample of foster care children found that 14% were taking psychotropic medications: two to three times the rate of non-foster children [36]. One study reported an increased rate of antipsychotic use from 8.9% to 11.8% across 45 states over the period of 2002–2007 [37], and another found a 37.9% annual prevalence rate of psychotropic medication use for youth in foster care [38]. Among those taking medications, 72% took two or more psychotropic medications, while 41.3% received three or more medications. Data on residential care have shown substantially higher rates of psychopharmacology, with an average of 75–79% of youth in these settings taking psychotropic medications including high rates of polypharmacy [39]. Foster youth are prescribed antipsychotic medications, mainly for behavioral dyscontrol, at a higher rate than non-foster youth. Allaire et al. (2016) examined Medicaid claims from 36 states between 2000 and 2003 and found "morbid obesity" as a diagnosis at a prevalence rate of 0.5%. They also found the risk higher in females, non-White, and older adolescents and taking two or more second-generation antipsychotics increases the risk fivefold [40]. Persistently high rates of treatment with antipsychotics, particularly among foster children, gaps in metabolic monitoring, overuse of multiple concurrent antipsychotic medications, and underuse of psychosocial interventions illustrate behavioral healthcare challenges [41].

Psychosocial Treatment

Although rates of congregate care are on the decline, older youth in foster care are more likely to be placed in a congregate care, with rates approaching 60% [42, 43]. These older youth entered residential treatment facilities or group home settings instead of a family foster care home mainly for behavioral problems and required trained staff to provide care to address those issues. Unfortunately, they are less likely to be adopted, most likely emancipate from child welfare, and require support through their transition. The research base for residential group treatment effectiveness is not robust, but there is a correlation between the youth's level of functioning and their level of care in the community. Multidimensional Treatment Foster Care (MTFC) addresses the difficulty of leaving institutional care and involves a large behavior management team, including foster family involvement with treatment to support reunification. MTFC has become popular in the juvenile justice system as an alternative to youth incarceration, but it has not been widely adopted in child welfare or mental health systems [42].

There are other supports systems and approaches that help foster youth make the transition to adulthood. The Youth-Initiated Mentoring (YIM) model encourages young people to reach out and ask their potential natural supports to engage with them more and be in a relationship with them as a mentor, which could be applied among young adults with mental health conditions [21]. Another program, SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress), aims to enhance adolescents' abilities to cope more effectively in the moment, to cultivate consciousness, and to create connections and meaning. It draws upon mindfulness and interpersonal skills from dialectical behavior therapy for adolescents, problem-solving skills, and enhancing social support and planning for the future. Mindfulness is explained to group members as "paying attention in a particular way, on purpose, and nonjudgmentally." SPARCS's focus on mindfulness, coping, and interpersonal skills makes it an ideal treatment for adolescents transitioning to independence [44]. For youth with a known history of trauma who struggle with symptoms of post-traumatic stress disorder, trauma-focused cognitive behavioral therapy (TF-CBT) has a robust evidence base for the treatment of PTSD and is recommended for first-line treatment for PTSD symptoms over medication [45].

Challenges to Address When Working with Young Adult Foster Youth

Childhood adversity is common, and the types of adversity can range from the parental separation and divorce to child abuse and neglect. But youth in the child welfare system have often undergone multiple adverse experiences which directly affect health. Research has shown a dose-response relationship between the number of adverse childhood experiences (ACEs) and increased risk of morbidity and mortality impacting health and mental health outcomes [46, 47]. Looking at the impact of ACEs on young adult foster care alumni, data from the Midwest Study show distinct subgroups related to the type and number of ACEs to which youth have been exposed. Young adults categorized as "the complex adversity group" who had high rates (average 7) of ACEs also had the highest rates of physical health and sexual health risk factors when compared to youth in the "environmental adversity group" who were only exposed to environmental adverse experiences such as a natural disaster or community violence. Not surprisingly, youth with the lower ACE scores (an average of 2.8), categorized as "the lower adversity subgroup," had the lowest risk of poor health outcomes [48].

Exposure to adversity and trauma can lead to negative physical and behavioral health outcomes. Youth in the child welfare system have often been exposed to not just one trauma but multiple traumatic events that are often chronic and cumulative. They often lack the protection and support of a parent or adult caregiver to help buffer the effects of trauma. "Toxic stress"

is a phenomenon that characterizes the negative mental and physical health effects of exposure to chronic trauma, which persistently activates the body's neuroendocrine stress response system contributing to the negative health effects [49]. This activation has a direct negative effect on gene translation, immune system response, and neurodevelopment [50]. Chronic glucocorticoid exposure from the toxic stress response has a direct effect on key areas of the developing brain including the amygdala, hippocampus, and prefrontal cortex. These changes interfere with the development of emotion regulation, impulse control, concentration, and decision-making. An emerging body of research has shown that toxic stress may impact the way genes are transcribed through epigenetic changes to DNA sequences. These genetic changes may contribute to how the body responds to stress, impacting mental health [51]. Toxic stress also has a direct effect on physical health. A large body of research shows that youth in foster care, compared to non-foster peers, have increased rates of acute and chronic infections, asthma, and obesity. This is due to the physical sequelae of trauma but is also directly related to toxic stress-induced chronic immune response and inflammation [52].

Social supports can provide a buffer against the long-term effects of trauma and help youth transitioning out of care. Social supports are a central factor in well-being, impacting physical and mental health in individuals exposed to trauma. The impact of early adversity for youth aging out is linked to not only structural aspects of support such as network size but also a youth's ability to recognize and utilize available support. Efforts are needed to help build this skill set for youth aging out [53]. Foster youth transitioning out of care often lack the support network so greatly utilized by their non-foster peers as they take on more independence. Multiple moves and school settings make it difficult to form and maintain relationships [54]. Disrupted social networks are linked to higher rates of emotional distress. These frequent moves and traumas can also instill a lack of trust in people [55]. Lack of supports and social connectedness contribute to negative outcomes and increased challenges with transitioning to adulthood [56].

If not already connected, youth transitioning out of care often reconnect with their family of origin. About 64% of transition-age foster youth reported feeling very or somewhat close to their birth mothers. If they were living with relatives, nearly 95% of youth reported feeling very or somewhat close to those relatives [57]. While birth families can provide critical support during transition, reconnecting with families can also be stressful for youth. Prior to aging out, systems should be put in place to help foster youth make informed decisions around reconnecting, form realistic expectations, establish appropriate boundaries, navigate family of origin interactions, and develop skills to address possible negative interactions.

With this social vulnerability, concerns have been raised around minors in the child welfare system being at risk for child sex trafficking. On interviewing victims of sex trafficking, many of these youth were found to have histories of child welfare involvement, maltreatment, and out-of-home care [58]. The 2014 federal legislation Preventing Sex Trafficking and Strengthening Families Act shed light on this concern and aimed to provide pathways for healthy relationships to develop. Females with a history of child sexual abuse are at particular risk to engage in transactional sex for youth who recently aged out [59]. Understanding these risk factors can help drive new practices and policies which help young adults during this vulnerable developmental period.

The impact of parental incarceration in this population is also important to consider. The United States has an incarceration rate that is five to ten times higher than that in other industrialized nations and is unique in its proportion of children experiencing a parent undergo incarceration. Positive, significant associations were found between parental incarceration and health problems such as depression, post-traumatic stress disorder, anxiety, cholesterol, asthma, migraines, HIV/AIDS, and reported fair/poor health [60]. Youth in the child welfare system

have increased lengths of stay when they enter due to parental incarceration when compared to other reasons for removal [61].

Best Practices: Promoting Resiliency

Child welfare systems value strengths-based approaches and resilience orientations [62]. Masten (2001) defined resilience as a class of phenomenon characterized by good outcomes in spite of serious threats to adaptation or development and emphasized that resilience is a common rather than extraordinary characteristic of individuals [63]. Ungar (2013) conceptualized resilience among maltreated youth as an interactive process between youth and their social ecology, which is influenced by youth individual characteristics (temperament and personality), the social determinants of health affecting youth and their caregivers, the quality of services provided by stakeholder agencies, and government policies addressing high-risk populations. Resilience can be promoted by ensuring the availability and accessibility of social supports and formal services and program flexibility to address individual youth specific needs [64].

A resilience orientation portends a strengths-based approach that identifies and enhances protective factors in a youth's environment. Foster youth strengths often include persistence, resourcefulness, determination, grit, and self-reliance. Latent class analysis identified four subgroups of young adults in the Midwest Study. The subgroup termed "accelerated adults" who viewed themselves as "having to grow up fast" and "take on adult responsibilities" tended to have better outcomes such as higher rates of employment and decreased involvement in criminal justice system. This group comprised about one-third of the study participants and was majority female [65]. The Midwest Study also found that foster youth with high school diplomas or GEDs were almost twice as likely to be employed as an adult [66].

Connectedness in youth who are transitioning out of care is a protective factor. Youth placed in kinship placements, compared to non-relative care, have better outcomes and more social supports [56]. Encouraging mentoring relationships can promote success, especially when working with youth in non-kinship placements. Foster youth with a positive and significant relationship with at least one adult, compared to non-mentored foster youth, fare better on general health, feelings of stress, education attainment, physical aggression, suicidality, arrests, and sexually transmitted diseases [55]. Some supportive adults enter youth's lives through interactions with the child welfare system. Important qualities of the mentoring relationship include trust, consistency, empathy, and authenticity. Transition-age foster youth value mentors who are understanding and non-judgmental, provide direct communication and advice, and have similar life experiences that they share [67].

Best Practices: Assessment of Readiness

The Casey Life Skills website contains resources for youth and coaches (providers or caregivers) to help foster youth achieve their long-term goals. The Casey Life Skills Assessment (CLSA) is a tool that helps youth self-evaluate the behaviors and competencies necessary for successful transition to adulthood (casey.org-life-skills-resources/) (Fig. 22.7).

Casey Life Skills also provides additional life skills assessments for youth with specific characteristics and circumstances. These additional assessments include assessments for healthy pregnancy, parenting of infants, and parenting young children; education assessments based on schooling level and education supports for support and assistance (Individualized Education Plan (IEP) and 504 Plan); and assessments for gay, lesbian, transgender, and questioning (GLBTQ) youth, American Indian youth, homeless youth, and younger youth with reading or developmental challenges.

After the CLS Assessment, youth and coaches can use the Resources to Inspire Guide to develop a plan for acquiring needed skills. The guide con-

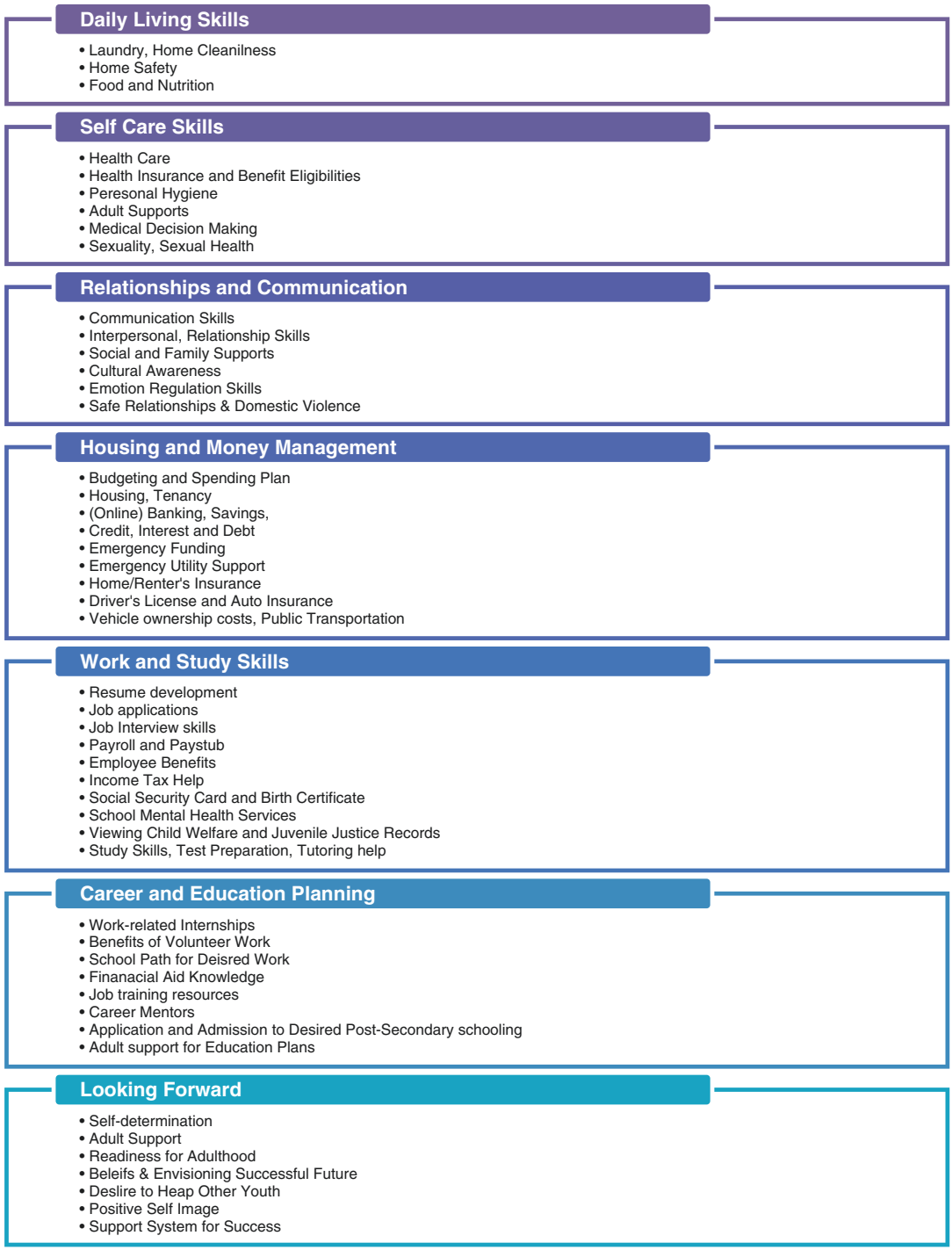

Fig. 22.7 Casey Life Skills Assessment: core competency domains. (Adapted from Casey Family Programs. Casey Life Skills [68])

tains suggestions for free or low-cost life skills training resources and encourages searching for additional resources [68].

Promising Practices

The California Evidence-Based Clearinghouse for Child Welfare (cebc4cw.org) is an online resource whose mission is to "advance the effective implementation of evidence-based practices for children and families involved with the child welfare system." The site includes a program registry and ratings of the strength of evidence for specific programs and practices. Ratings range from 1, Well-Supported by Research Evidence, to 5, Concerning Practice, and NR, Not able to be Rated on the CEBC Scientific Rating Scale. Youth Transitioning into Adulthood is one of the topic areas (cebc4cw.org-transition). At this time, in the Transitioning into Adulthood category, one program is rated 2—Supported by Research Evidence (Better Futures, described below)—and three are rated 3, Promising Research Evidence. The remaining 16 programs are rated NR—Not able to be Rated—due to a lack of available research evidence. Some of these programs target individual functional domains, such as social supports, housing, education, employment, living skills, financial literacy, health, and mental health. Other programs are more comprehensive and target multiple domains. Some are child welfare-specific, while others target general high-risk transitional age youth [69].

Education: "Better Futures" Program (Rated "Supported by Evidence" 2 Out of 5 for Strength of Evidence)

Better Futures is a program focused on improving postsecondary preparation and participation of youth in foster care with mental health concerns. The target population is youth and young adults in foster care, including youth with disabilities and/or mental health concerns, who are in their final year of high school or GED completion, open to participating in postsecondary education, and allowed to go into the community with their Better Futures Coach. Youth participate in a 4-day postsecondary school immersion experience followed by 9 months of (1) youth-directed relationship support from a coach in postsecondary education and personal experience in foster care; (2) coaching in applying achievement, partnership, and self-regulation skills to identify and attain related youth-chosen goals; (3) support for experiential activities related to career and postsecondary exploration and preparation; and (4) workshops bringing together youth, coaches, and successful near peers for learning, peer support, and networking.

A Better Futures randomized controlled trial evaluated outcomes of 67 youth involved with the Oregon child welfare system who also had some type of operationally defined mental health concern. The Better Futures intervention consisted of a 4-day 3-night Summer Institute on a university campus; individual, bimonthly peer coaching; and four mentoring workshops. At 6 months after the 10-month intervention, youth in the Better Futures group, compared to the control group, were twice as likely to participate in postsecondary education. They also scored higher in transition planning and rated themselves higher on standardized measures of self-determination, mental health empowerment, and hope. The Better Futures group trended positively in high school completion and standardized self-reports of mental health recovery and quality of life [70].

Mentoring: "Caring Adults R Everywhere" Program (Not able to be Rated)

Relationships with caring non-familial adults can enhance youth resiliency (Collins, 2010). The Caring Adults R Everywhere program is a manualized 12-week mentoring intervention designed to bolster social supports by developing and strengthening existing relationships between youth and supportive adults from the youth's natural ecology [71]. A master's-trained social worker (not the youth's child welfare worker), called an interventionist, meets with a youth

aging out of foster care to identify an appropriate mentor. After screening and approval, mentors undergo training in adolescent development, the child welfare system, trauma-informed mentoring, practices of effective mentors, what to do with one's mentee, and establishing and maintaining boundaries. Youth and mentors participate in group activities and one-on-one sessions with the interventionist to strengthen and clarify expectations for the mentoring relationship.

Homelessness: "My First Place" Program (Not able to be Rated)

Foster youth experience homelessness at much higher rates than their same-age peers. The My First Place (MFP) program, located in the San Francisco Bay Area, targets transition-age foster youth at risk for homelessness [72]. The program typically lasts 18–24 months and is comprised of five core elements:

1. Ongoing case management by a youth advocate, the primary case manager, and an education and employment specialist. Foster youth work with both to achieve specific goals in the area of housing, education, employment, and healthy living.
2. MFP uses scattered site housing throughout the five-county region. The program seeks housing in safe neighborhoods near public transportation. MFP typically signs a master lease with landlords and then subleases units to program participants. Youth receive training on tenancy.
3. MFP has a property management department that maintains relationships with landlords and affordable housing partners, rents apartments, manages subleasing, oversees move-ins, and manages rent payment. The department also deals with tenant issues like property damage, maintenance, and compliance with regulations.
4. A larger organization infrastructure provides administrative and clinical support.
5. MFP collaborates with community partners, including referral sources for program youth, education and employment partners, and health and mental health provider agencies.

Financial Literacy: "MyPath Savings" (Not able to be Rated)

Limited financial knowledge and capabilities can undermine efforts to achieve financial stability. MyPath Savings is a financial knowledge and skills program for economically disadvantaged youth earning their first paychecks [73]. The program provides financial education, familiarizes youth to conventional financial products, and uses experiential teaching with peer learning and support. Topics and skills include direct deposit, checking and restricted savings accounts, and savings incentives. Youth are aided to open accounts, set up direct deposit, set a savings goal, and save a designated portion of each paycheck and provided incentives to meet savings goals.

Postsecondary Education Support

Most foster youth aspire to attend college. However, foster youth enroll in and graduate from college at much lower rates than their non-foster peers [74]. Foster youth often report that few people in their lives expect and/or encourage them to attend and succeed in college. In addition, foster youth experience a number of risk factors that negatively impact education [75]. A number of states are developing programs to support foster youth and alumni in postsecondary education, including college, community college, and vocational training. More than 30 states provide scholarships, grants, or tuition waivers to foster youth attending higher education. Casey Family Programs developed a resource report called Supporting Success that identifies and discusses 12 core program elements for improving outcomes [76] (Fig. 22.8).

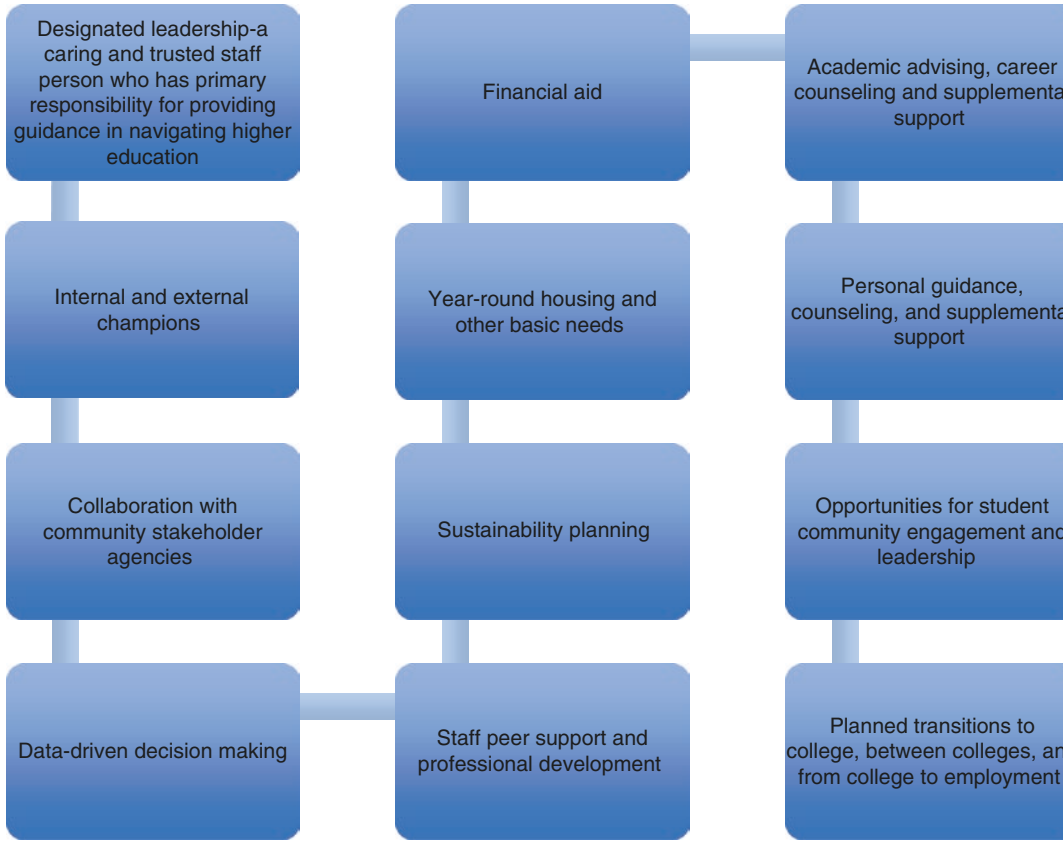

Fig. 22.8 Casey Family Programs supporting success core program elements. (Adapted from Casey Family Programs [76])

The Seita Scholars Program is a campus-based support program for foster youth and alumni attending Western Michigan University [77]. The program is named after Dr. John Seita, a graduate of the Michigan child welfare system and Western Michigan University. Coaches provide support to students in the program—Seita Scholars—with a focus on the seven lifespan development domains suggested by Casey Family Programs, academics, finances and employment, housing, physical and mental health care, social relationships and community connections, cultural and personal identity, and life skills. The program includes a scholarship at Western Michigan University. Students reside on campus and have access to 24-hour on-call support and emergency financial resources. The program uses trained master's-level campus coaches and provides training and certification for professionals working with college students who have been involved in the foster care system or other high-risk youth.

Independent Living Programs

Federal legislation provides funds to states to offer independent living programs to assist foster youth and alumni transitioning to adulthood. Program components typically involve social-emotional supports, mentoring, housing, education and training, employment, daily living skills, health and behavioral health, and financial literacy.

The Orangewood Independent Living Program (ILP) was developed by the Orangewood Foundation and provides workshops, special events, mentoring, and case management to fos-

ter youth 16–21 years old to help prepare them for the transition to independence [78]. Each month the ILP focuses on one of four key areas: education, career, relationships, and daily living, providing workshops and take-home activities. Youth can earn ILP dollars by participating in workshops and special events and completing take-home assignments. Examples of take-home activities include writing an interview thank you letter (career), completing a change of address form or getting a credit report (daily living), completing a FAFSA application (education), and identifying one's core values or completing a roommate agreement (relationships). The ILP dollars are tracked in an Orangewood bank account, and ILP youth can purchase a maximum of one $50 gift certificate per month for use at stores for groceries, clothing, and general goods. ILP dollars can also be used for bills and rent. Youth must plan the use of ILP dollars, because processing requests may take up to 2 weeks and staff may discuss the youth's requests. Foster care alumni who have successfully transitioned to independent living serve as peer mentors in the ILP. Peer mentors help establish program rapport and credibility with ILP youth, teach independent living skills, facilitate small group discussion during workshops, and serve as positive role models. Participants provide feedback at each workshop to assess interest and effectiveness (Fig. 22.9).

Supportive individuals are invited to participate in the youth's transition plan and attend workshops. ILP also coordinates with other programs designed to serve transition-age foster youth, such as housing, scholarships, Independent Living Specialists, and youth leadership opportunities.

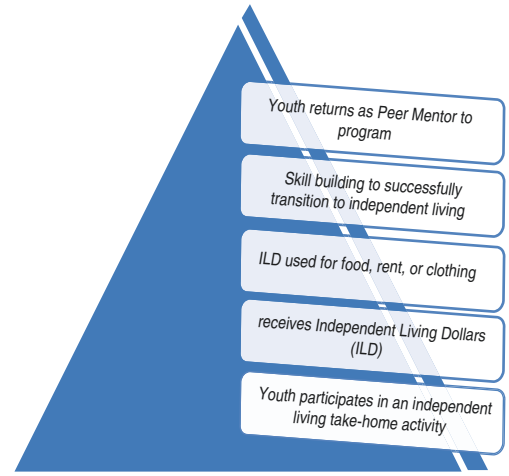

Fig. 22.9 Orangewood Independent Living Program process. (Adapted from California Evidence-Based Clearinghouse for Child Welfare. Independent Living Program Orangewood http://www.cebc4cw.org/program/independent-living-program-orangewood)

Legal and Ethical Issues

Ethical, legal, and policy issues overlap because state responsibilities to foster youth should translate into policies and legislation. Given that most non-foster youth require and receive social, pragmatic, and financial support from their parents well into their 20s and beyond, one can make the case that the state and society are ethically bound to provide comparable support for a similar duration to foster youth. Vast geographic disparities in public health and behavioral health care and child welfare systems require contemplation from child and adolescent behavioral health providers and stakeholders. It is imperative to advocate for changes within local, state, and federal governments to ensure access to comprehensive services owed to this highly vulnerable population.

Behavioral health clinicians should provide and advocate for the appropriate use of psychiatric medications and trauma-informed psychosocial treatments. When working with youth who are in the care and protection of the state, providers should familiarize themselves with state laws around mental health treatment and psychotropic consent. Authority for psychotropic consent varies from state to state and may rest with the biological parents, a child welfare agency, or some other party such as a court or state-appointed consent agent. Questions about a youth's legal status, consent, release of information, and legal authority should be directed to the child welfare worker. Issues around consent and privacy have also left much of this vulnerable population out

of clinical trials and other research studies, impacting the amount of evidenced-based literature on this population.

Areas of Need: Research and Policy Gaps

The Institute of Medicine and the Future of Children contemplated transition, including research and policy gaps relating to "marginalized" and "vulnerable" youth transitioning to adulthood [79, 80]. Foster youth were included in these groups, along with youth involved with the juvenile justice, mental health, and special education systems, and youth with disabilities. More research on transition-age services for foster youth is needed. A more comprehensive understanding of transition-age foster youth and outcomes will inform policy and program development. Many existing programs appear promising, but more research is required to determine the effectiveness and cost-effectiveness of programs and inform quality improvement. States are given wide latitude to develop transition programs; differences in state transition services provide opportunities to compare implementation processes and functional outcomes. Databases must be expanded, strengthened, and linked to support more rigorous evaluation and outcome tracking. Administrative data may include relevant information, including secondary and postsecondary education performance, health and behavioral healthcare utilization and outcomes, employment, justice system involvement, and participation in public assistance programs.

Legislation and policies have begun to address the myriad challenges facing transition-age foster youth, but to sufficiently support foster youth emancipation and self-sufficiency, federal legislation and policies must be strengthened to expand the availability and breadth of transition services. While recent federal legislation seeks to extend state responsibility to act as parents to foster youth beyond age 18 years, it does so mostly to age 21 years, too young given most foster youth's developmental needs. Most states provide transition services in a limited, interrupted, and piecemeal fashion, contrasted with the more comprehensive, continuous, and enduring supports many parents provide their children. Transition-age foster youth may be involved with multiple agencies because they have multiple needs, requiring integration and coordination of efforts. Moreover, federal legislation permits but does not require states to provide necessary transition services. For example, only about half the states offer Extended Foster Care, and those that do often offer more limited services than federal policies allow [81]. In addition, while states must extend Medicaid eligibility to age 26 years to foster youth from their own state, most states do not do so for foster alumni from other states [16].

Existing programs are too bureaucratic, inaccessible, idiosyncratic, fragmented, poorly responsive, and stigmatizing [80]. Transition-age foster youth will benefit from policies promoting a youth-centered, family-focused, culturally sensitive, developmentally appropriate, accessible, responsive, comprehensive, and integrated and coordinated system of transition care. This care should be continuous and seamless from adolescence to early adulthood, trauma-informed, nonstigmatizing, and socially inclusive. Accountability for outcomes must be heightened to improve the well-being of foster care alumni.

Summary

Transition-age foster youth do not typically receive the range of family supports that their non-foster peers enjoy. Foster youth often experience multiple adversities that complicate successful transition and negatively impact mental and physical health. Foster care alumni are at increased risk for negative outcomes in education, homelessness, employment, financial security, health, and behavioral health. Youth-serving public systems of care often end at age 18 or 21 years or are discontinuous with adult approximations. The federal government, states, foundations, non-government organizations, families,

and current and past foster youth have begun addressing transition-age foster youth needs. Many policies and programs appear to be promising. More research is needed to assess the effectiveness and efficiency of existing programs and to inform program and policy development and quality improvement. Policies must be strengthened to increase accountability for developing youth self-sufficiency and improve transition service availability, access, responsiveness, continuity, duration, and effectiveness.

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