Annotated Bibliography
Supporting High-Risk Foster Youth in Transition: Research Findings

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Children who are removed from their homes are necessarily at high risk for multiple negative outcomes; they come to the attention of the state precisely because of that risk. Presumably, these children will have the opportunity to develop a better trajectory in the context of foster care. Foster care providers, then, have a responsibility to demonstrate that the children in their care do, in fact, have improved outcomes. This is not easily done: how can one define "better"? Is the comparison group high-risk children in institutions, adoptive homes, or the general population? None of these options is satisfactory methodologically. If in a longitudinal study the foster youth serve as their own controls, the high risk of this group means that a successful intervention may still result in poorer outcomes than seen in the general population. Moreover, part of the difficulty in determining whether children have improved outcomes is deciding what constitutes a good outcome. The formidable research issues have made examining outcomes of foster care a topic that is not easily studied, and hence a good subject for an intensive review of the literature.

Another important issue in foster care outcome research is the age of the child: the younger a child is when placed in a family setting, the better the outcomes tend to be (Nelson et al., 2007). Arguably, the youth transitioning out of foster care have serious risks and also are the best population for examining outcomes. Accordingly, this review focuses on older adolescent foster children in transition from care.

This review searched for any articles published since January 2000 that described interventions for adolescents in and aging out of foster care in the United States. Articles about interventions for all ages were included, to the extent that their application to adolescents was described. Interventions related to kinship and nonkinship care were considered; however, interventions for the family of origin (for example, to prevent reinvolvement of child welfare after the child has reunified with the family) were excluded. Interventions for other related groups were also excluded. For example, even though other children at high risk might have similar needs and benefit from similar outcomes, research about high-risk children in general was excluded. Likewise, children from homeless families may have very similar needs, especially in regard to developing independent living skills; interventions targeting these children may well be applicable to foster children too. However, this review focuses on interventions that are specifically targeted to adolescent foster children. Finally, for the purposes of this review, research about interventions applied in other countries was also excluded. There is certainly excellent research from other countries, but it is not at all clear how differences in culture, social institutions, and general attitudes toward child welfare and foster care might moderate or mediate the effect of an intervention. Approximately 75 articles were reviewed, with 13 selected for inclusion here.

As mentioned earlier, selecting appropriate outcomes by which to evaluate an intervention is itself a complicated task. Based on the articles reviewed, several possible outcomes of interest stand out:

- Mental health outcomes, such as symptoms of depression or post-traumatic stress disorder

- Educational outcomes, both short-

term (as in attendance) and long-term (as in graduation from college)

- Placement stability, either through reunification, adoption, or simply prevention of premature placement disruption

- Independent living, or independence upon aging out of foster care

- Reduction in risk of violence or delinquency

- This review is organized around these outcomes, with an additional section regarding particularly promising treatment modalities.

For further reading:

Barth, R., Greeson, J., Zlotnik, S., & Chintapalli, L. (2009). Evidence-based practice for youth in supervised out-of-home care: A framework for development, definition, and evaluation. *Journal of Evidence-Based Social Work, 6*(2), 147–175.

Naccarato, T., & DeLorenzo, E. (2008). Transitional youth services: Practice implications from a systematic review. *Child & Adolescent Social Work Journal, 25*(4), 287–308.

Nelson, C. A., Zeanah, C. H., Fox, N. A., Marshall, P. J., Smyke, A. T., & Guthrie, D. (2007). Cognitive recovery in socially deprived young children: The Bucharest Early Intervention Project. *Science, 318*(5858), 1937–1940. doi:10.1126/science.1143921

What interventions improve mental health outcomes?

The mental health of youth aging out of foster care is arguably among the most important outcomes, because a person with sound mental health will be better able to manage any other challenges. Furthermore, in the past decade, research has demonstrated a significantly higher incidence of certain mental disorders among foster care alumni, including post-traumatic stress disorder, anxiety disorders, depression, and substance abuse (see Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). In spite of high utilization of mental health services, there are even more children who need services; Levitt (2009) estimated that 1,086,000 children did not receive needed services in 2001. The importance of mental health among foster children is also evident from the dedication of an entire recent issue of *Child Welfare* (volume 88, number 1) to mental health interventions for foster children. Many online resources maintain up-to-date information about evidence-based treatments, including the REACH Institute (www.thereachinstitute.org), which has specific guidelines for child welfare; and The National Child Traumatic Stress Network (http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom), which has fact sheets regarding evidence-based interventions.

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children & Youth Services Review, 31*(11), 1199–1205.

Weiner, Schneider, and Lyons studied three evidence-based treatments, one each for 0- to 6-year-olds, 3- to 16-year-olds, and 13- to 21-year-olds. For the purposes of this review, I will focus on the latter two: Trauma-Focused Cognitive Behavioral Treatment (TF-CBT) for 3- to 16-year-olds, and Structured Psychotherapy for Adolescents

Responding to Chronic Stress (SPARCS) for those age 13 years and older. Information sheets about both of these programs are available on the National Child Traumatic Stress Network Web site just mentioned. According to their descriptions, TF-CBT is a weekly, 60- to 90-minute, psychoeducational and therapeutic intervention that works with parent and child both separately and together to manage trauma-related symptoms. SPARCS is a 16-week group intervention that is primarily cognitive-behavioral and aims to improve self-efficacy, relationships with others, and awareness and meaningfulness in life. These interventions were provided across multiple sites and multiple agencies, and were targeted toward children who had experienced trauma and had related adjustment problems.

The strength of this particular study was that it disaggregated the results by race, so that the efficacy of each intervention for children of each race could be compared. Unfortunately, the sample did not include strong representation of Hispanic or biracial children, so the strongest comparison of treatments across races is between African-American and White youth. However, the authors conclude that the interventions work well across racial groups; they further theorize that the children may not even belong to distinct cultures, but rather primarily to the culture of child welfare.

Based on their experiences that TF-CBT and SPARCS worked equally well across groups, they focus their recommendations on adapting interventions to minimize barriers, which may be in part based on culture. They recommend being flexible about who participates in treatment (any willing family member or substitute caregiver, foster and birth parents if appropriate), about providing arrangements for transportation or offsite interventions, and even about how the intervention is applied: "TF-CBT therapists allowed children to use alternate forms of narration for the trauma narrative. For example, one child preferred to complete her trauma narrative using dance and movement rather than words" (p. 1204). It is easy to imagine an adolescent who prefers poetry or rap to a traditional narrative benefiting from the provider's flexibility regarding multiple and alternate forms of narration.

Cantos, A. L., & Gries, L. T. (2010). Therapy outcome with children in foster care: A longitudinal study. *Child & Adolescent Social Work Journal*, 27(2), 133–149.

Cantos and Gries undertook a study of therapy as it occurs for foster children. Citing research that laboratory-controlled child therapy does not generalize well to the field, Cantos and Gries came at the research from the other direction, attempting to understand what happens in therapy for foster children. Although this means that their study does not meet the gold standard of a randomized controlled trial, the strength of this approach is that it captures the reality of how therapy happens. It also gives some important insight into how we measure change in mental health.

Cantos and Gries studied foster children, ages 4 to 17, treated at four different offices of a private agency in New York City; initially referred for emotional or behavioral difficulties at school or at home, these children were treated by 18 different therapists of various theoretical orientations. The researchers used three instruments, one scored by the foster parents (Child Behavior Checklist, or CBCL), one by teachers (Teacher Report Form, which is parallel to the CBCL), and one by the therapists (Acuity of Psychiatric Illness Scale). The parent and teacher scales were collected initially and every six months thereafter for 18 months; the therapist scale was collected initially, after three or four sessions, and every three months thereafter.

Some of the most interesting findings of this study relate to how much the rating of a child's problems depends on who is doing

the rating. In their analysis, Cantos and Gries see that foster parents rate problems as being more severe, which is apparently consistent with other research. However, the reason for that difference in ratings remains problematic: Is this is a reflection of the children's demonstrating different behavior (for example, the children show fewer behavioral problems in the structured school environment)? Is it a reflection of the adults' prioritizing different things (such as teachers being more concerned about problems that directly interfere with learning)? Is it a result of external influences (for example, foster parents who may be motivated to inflate problems in order to receive higher payments from the state)?

This question of measurement is further complicated by the fact that the raters also rate the change over time differently. In Cantos's and Gries's research, at the same time that the therapists rated the children as improving, the teachers rated the children as deteriorating; in fact, the teachers' later scorings are similar to the foster parents' scoring at the beginning of the study. Cantos and Gries propose multiple possible explanations for this: perhaps the teachers get to know the children better; perhaps the children's problem behavior slowly generalizes across areas; perhaps the measurements themselves, as reminders that the children have difficulties, become self-fulfilling prophecies. It seems likely that in addition to teachers knowing the children better, the children also become more comfortable showing their unhappiness as they get to know the teachers better.

However, without any real evidence for why foster parents, teachers, and therapists rate children differently, it is difficult to know which rating reflects the reality of what is happening with the child: therein lies the real difficulty with developing interventions to improve mental health outcomes for foster children. If different observers disagree as to whether a child's behavior is improved, whose ratings do we privilege? Cantos and Gries were looking at children of all ages, but I suspect that this issue would be even more extreme when looking only at adolescents, as it is common for adolescents to be taciturn, rebellious, or otherwise antagonistic toward adults as they strive to develop independent adult identities.

Cantos and Gries did record some other interesting findings, though it is difficult to know how they would generalize. The two-thirds of the children in their study who improved with therapy showed improvement within seven months; the ones who did not were also the ones who presented with the most aggression at the outset. They suggest that mental health providers should consider adjusting interventions for those who do not respond within seven months, and that perhaps special interventions should be developed to target aggression.

Summary

It is difficult to know how to reconcile the different perspectives of parents, teachers, and clinicians in regard to the assessment of foster youth, for the purposes of both establishing a baseline and observing change over time. However, a large number of youth will benefit from therapeutic interventions, and those interventions appear to be equally effective across diverse groups. Furthermore, it may be possible and advisable to develop targeted interventions for those who are not benefiting (that is, those who start out with the most aggression).

With this and other tested interventions, the most important piece may be the flexibility in addressing logistical issues, which will come up again in a later discussion of educational outcomes; it was a common theme across multiple studies that one of the major obstacles to treatment was transportation and other logistical considerations. To the extent that an agency can help foster children and their families actually utilize the services that are available, this in itself may be pivotal to effective intervention.

For further reading:

Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Reutz, J. A. R. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare, 88*(1), 49–69.

Levitt, J. M. (2009). Identification of mental health service need among youth in child welfare. *Child Welfare, 88*(1), 27–48.

Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., and Ortiz, A. (2009). Mental health services for children in foster care: An overview of current challenges. *Child Welfare, 88*(1), 5–26.

Reifsteck, J. (2005). Failure and success in foster care programs. *North American Journal of Psychology, 7*(2), 313–326.

Schneiderman, J. U., & Villagrana, M. (2010). Meeting children's mental and physical health needs in child welfare: The importance of caregivers. *Social Work in Health Care, 49*(2), 91–108.

What interventions improve educational outcomes?

For adolescents transitioning from foster care, the educational context can be high school or college, and outcomes can range from the proximal to the distal. The most proximal educational goals have to do with attendance and homework completion. As with placement stability (discussed later), the outcome in this case is a goal in itself but also contributes to further positive outcomes. School attendance and homework completion are valuable in themselves, in their contribution to graduation, and in the fact that school attendance gives the child access to the multitude of other services available on campus. The most distal goals relate to graduation from college and successful employment and high earnings down the road.

Education as a locus of intervention also holds promise, as the provision of services through school does not require any additional effort on the part of the foster parents. In a review of the barriers to accessing mental and physical health care services, Schneiderman and Villagrana (2010) reported that foster children's underutilization of care can result from cost, when Medicaid imposes a monthly expenditure limit per person; or when placement disruption results in disruption in benefits as well; or from simple logistical barriers, such as transportation and obtaining child care for the other children in the household. When children are attending school, they can access adjunct services in the school as well, which reduces the impact of the barriers identified by Schneiderman and Villagrana. In the school where I worked, for example, students who were wards of the state could receive all primary care services through the school-based health care center at a reduced cost; they could receive mental health care services through the school social workers and through various agencies that maintained offices on campus; they had access to free breakfast and lunch; and they had the potential to connect with various other peer groups and mentoring adults. The difficulty for foster children is that placement disruptions also cause disruptions in education and prevent the children from taking advantage of all that the school setting has to offer.

Zeitlin, A., Weinberg, L., & Kimm, C. (2004). Improving education outcomes for children in foster care: Intervention by an education liaison. *Journal of Education for Students Placed At Risk, 9*(4), 421–429.

Zeitlin and her colleagues examined the use of an education specialist (ES) to determine whether some of the obstacles facing foster children could be better handled and result in better educational outcomes for the children. They describe many of the obstacles that foster children face in schools, including "difficulty accumulating school credits, falling behind in academic skill areas, placement in classes already

taken, delay in transfer of school records, and difficulty being evaluated for special education placement" (p. 422). Often the child welfare worker can manage obstacles that arise, but the program researched here provided an ES to handle those obstacles that the child welfare worker was unable to resolve.

The ES was a certified special education teacher who was partnered with a nonprofit law firm that she could consult at any time. The child welfare agency where she was placed served approximately 8,000 children, and 160 were referred to her during her first year. While half of those referred had problems that were resolved within one or two contacts by the ES, 17% required more than 10 contacts or referral to the law office.

This study compared 60 of the ES's cases with 60 control cases. The control cases were from the general population of the agency (that is, the 8,000), and therefore did not face as many educational obstacles as the 60 in the intervention group. Data were gathered from the year prior to and the year following the ES program. The most promising finding compared the reading and math pretest and posttest scores of the two groups. For both reading and math, the treatment group's pretest scores were significantly lower than the control group's; at posttest, there was no longer a statistically significant difference. In fact, the scores for the treatment group went up in both reading and math, whereas the scores for the control group went down in both. As the authors point out, this is a promising finding for the program, but it underscores the challenges that foster children face in education in general: without any intervention, their scores followed the expected downward trajectory.

The ES in this study played a valuable role in navigating the complex interactions between the child welfare agency and the school, and with the support of a legal team she was in a strong position to help resolve any complicated situations that arose as foster children moved among schools. In some sense, her role represents the state's recognition of the importance of education and its commitment to providing some continuity in the educational career of foster children.

Dworsky, A., & Pérez, A. (2010). Helping former foster youth graduate from college through campus support programs. *Children & Youth Services Review, 32*(2), 255–263.

Hernandez, L., & Naccarato, T. (2010). Scholarships and supports available to foster care alumni: A study of 12 programs across the US. *Children & Youth Services Review, 32*(5), 758–766.

In these two articles, the authors explore ways to support foster care alumni through college. Dworsky and Pérez interviewed administrators and conducted an Internet survey of students. In their review, they identify six barriers to a college education: (a) lack of support and encouragement from the child welfare system; (b) lack of adequate preparation due to disrupted education and few college preparatory classes; (c) lack of the emotional and financial support that others typically receive from family; (d) lack of awareness of eligibility for financial aid; (e) greater likelihood of mental health issues; and (f) lack of support system at the colleges, which are not prepared to meet the unique needs of foster care alumni.

Hernandez and Naccarato, however, interviewed administrators at various universities and colleges that do offer some sort of support to foster care youth. They also identified six major obstacles, some of which are congruent with those identified in Dworsky and Pérez's review: (a) academic preparation, both in terms of knowledge and in terms of time management and study skills; (b) housing; (c) financial assistance, including help with money management; (d) the need for emergency assistance, primarily in terms of funding for unexpected expenses like medical emergencies or eyeglasses; (e) youth's personal challenges, including

mental health and problem-solving skills; and (f) the need for advocacy, both with the university and the child welfare agency. One respondent reported that agencies tend to disregard the problems of foster youth in college, because those youth are assumed to be already successful.

Some of Dworsky and Pérez's findings that are particularly noteworthy deal with the challenges the programs face in supporting foster care youth. Several of their respondents discussed the difficulty in identifying youth who are eligible for services (this theme actually runs throughout this review). Having the services available is not enough: a significant amount of effort must be put into maximizing utilization of the available resources. Current and former foster youth are eligible for up to $5,000 each year for educational expenses through the Education and Training Voucher Program; however, if they are unaware of the program and have not been identified by the college as eligible, they might not know to claim the funding. Dworsky and Pérez also emphasized the housing issue, noting that foster care youth require year-round housing because they have nowhere to go home to for the summer.

Both articles identify the emotional needs of foster youth in college as being significant. Attending college is a major transition, and any underlying vulnerability can manifest itself under the stress of college life. As described in the previous section, the histories of foster youth put them at great risk for mental health problems; naturally, those problems would be a challenge in the college environment, and it would be important to provide mental health supports in readily accessible ways on campus.

What interventions contribute to placement stability?

Placement stability can be considered a positive outcome in itself. Furthermore,

one study found that placement stability over the first 18 months predicted behavior problems independent of baseline attributes (Rubin, O'Reilly, Xiangun, & Localio, 2007). One possible target of intervention, then, would be improving and lengthening stability of placement. Koh (2010) compared kinship and non-kinship placements across multiple states. At six months, although there was variation across the states, children seemed more likely to achieve some form of stability (legal permanence, placement stability, or reunification) when they were placed in kinship care. One possible reason for this is that kinship foster caregivers tended to persist longer with challenging children (Farmer, 2009). Farmer also found that kinship foster caregivers tend to receive fewer services, and are therefore under greater strain. This in itself suggests that programs aimed at improved service utilization among kinship foster caregivers would be valuable.

DeGarmo, D. S., Chamberlain, P., & Leve, L. D. (2009). Foster parent intervention engagement moderating child behavior problems and placement disruption. *Research on Social Work Practice, 19*(4), 423–433.

Any interventions that improve mental health and reduce the disruptive behaviors of children are likely to improve placement stability. To target placement stability more directly, an intervention with the parents seems to be the most promising approach. Although this review did not uncover any interventions targeted at the foster parents of older adolescents, in one promising study, DeGarmo, Chamberlain, and Leve analyzed the extent to which parents' engagement with the parenting intervention affected their report of problem behavior of their foster children and negative placement outcomes. (This intervention was for parents of younger foster children, aged 5 to 12.) This study is valuable because it demonstrates that, within an intervention, those foster parents who become more engaged—as evinced by homework, openness to ideas,

participation, and satisfaction—have fewer problems with their foster children. This may in part be due to parents' being better able to manage the children's problem behaviors, and in part to the parents' being better able to understand difficult behaviors and therefore less likely to consider them problematic. The authors describe the steps they took to facilitate engagement: they provided child care, credit toward yearly licensing requirements, reimbursement for travel, and refreshments. Once again we see the theme of dealing with logistical barriers and assisting targeted participants in actually utilizing existing services.

Stott, T., & Gustavsson, N. (2010). Balancing permanency and stability for youth in foster care. *Children & Youth Services Review, 32*(4), 619–625.

While it seems intuitive that achieving permanence would be the ideal route to placement stability for adolescents, Stott and Gustavsson present a structural analysis of how the goal of permanency might in fact contribute to greater *in*stability for adolescents. Although permanency is, in fact, a better outcome, according to these authors' review of the research, adolescents in foster care represent a very small portion of children who are adopted, and are much more likely to exit foster care either when they are emancipated or when they reach majority age. We can understand this trend for adolescents not to be adopted as being partly a result of fewer families wanting to adopt older children, and partly a result of the adolescents' own reluctance to be adopted.

Stott and Gustavsson paint the picture of the person who enters the child welfare system as a young adolescent rather than as a child, and because of this is more conflicted about severing ties to his family of origin. He is moved initially into a group home, but because of the emphasis on permanency, he is then placed in a foster home to try out a possible adoptive family. The family

is reluctant to adopt an adolescent, and the adolescent is reluctant to be adopted because he experiences conflicting loyalties in his desire to remain connected to his family of origin. The placement fails, and he is moved back to the same group home, another group home, or another foster family. With permanency as a goal, workers work to place children in foster homes even after multiple placement disruptions. This results in adolescents experiencing more disruptions as they are continually re-placed with prospective adoptive families.

Summary

Most adolescents in foster care came into foster care later, and most exit foster care when they become emancipated or reach majority age. It may be that educating and supporting foster parents will improve placement stability, but it might be important to reconsider the placement stability goals for adolescents. Is the goal permanence, or is it maintaining the youth's current placement, even if it is a group home? Perhaps it makes most sense to think of permanency or stability for adolescents in terms of independent living, so that the intervention prepares the adolescent for long-term living stability.

For further reading:
Farmer, E. (2009). How do placements in kinship care compare with those in non-kin foster care?: Placement patterns, progress and outcomes. *Child & Family Social Work, 14*(3), 331–342.

Koh, E. (2010). Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects. *Children & Youth Services Review, 32*(3), 389–398.

Rubin, D. M., O'Reilly, A. L. R., Xiangun, L., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 119*(2), 336–344.

What interventions contribute to maximizing independent living?

In a recent review of independent living programs for adolescents transitioning out of foster care, Naccarato and DeLorenzo (2008, see previous citation) investigated practice-based implications of research over the past 40 years. While they looked at multiple outcomes of independent living programs—homelessness, educational attainment, employment—some of the common themes across the practice implications related to the fact that, at this moment in history and in this society, people are not equipped to be fully independent at the age of 18. Jeffrey Arnett's extensive research into the developmental age he calls *emerging adulthood* underscores the transitional nature of this age, even for people with optimal familial support (see Arnett's website for a partial bibliography of his work, www.jeffreyarnett.com/articles.htm). Throughout the multiple areas of practice implications, it is clear that even with independent living interventions, people continue to need guidance and mentorship after they reach the age of majority. This is not surprising, as people arguably need guidance and mentorship throughout life; however, it supports the more recent move toward providing some kind of permanent family or adult connection for youths who are aging out of foster care.

Avery, R. J. (2010). An examination of theory and promising practice for achieving permanency for teens before they age out of foster care. *Children & Youth Services Review, 32*(3), 399–408.

Avery, R. J., & Freundlich, M. (2009). You're all grown up now: Termination of foster care support at age 18. *Journal of Adolescence, 32*, 247–257.

Avery and Freundlich begin with a clear discussion about whether it is appropriate to expect 18-year-olds to be fully independent. Reviewing the research regarding 18- to 25-year-olds' decision making, she notes that although emerging adults have the same cognitive abilities as older adults, they are more influenced by emotions, especially when the emotions are strongly activated, as in perceptions of threats to survival. During this period of emerging adulthood, outcomes are strongly influenced by social capital, especially parents or other adults who can provide the support necessary to become an independent adult. Unfortunately, with a history of abuse or neglect, foster care alumni have fewer supportive relationships and greater difficulty establishing new ones; furthermore, agencies do not put effort into nurturing ties with family of origin or new mentors, thus leaving foster care alumni without the kind of support that emerging adults in this society need in the transition from adolescence to independent adulthood.

Although an 18-year-old might not need to be protected from abusive or neglectful family members in the way she did as a child, as Avery describes, there is an understandable reluctance to reconnect these children with their families of origin. However, without some form of safety net, former foster care youth who are in the stage of emerging adulthood struggle. Without adults or mentors, foster care alumni tend to develop deviant peer affiliations—connections with peers who have histories of work problems, mental health and substance abuse, and delinquency or criminality—which is hardly a suitable replacement. Avery and Freundlich conclude that, rather than independent living, policies and practices should be formed around *interdependent living*, with the understanding that youth at age 18 are not expected to be fully independent, and no one should exit foster care without a connection to at least one permanently committed adult.

To that end, Avery examined a practice model intended to build social capital for adolescents exiting foster care. The "Permanent Parents for Teens" program,

implemented at various residential and group homes around New York City, consisted of four components. First, Permanency Action Recruitment Teams, which consisted of the teen, any family members, and various staff members, worked together to identify adults already in the teen's life who could possibly act as a permanent adult connection. If the teen did not already have a connection with an appropriate adult, the agency worked to create opportunities for the teens to interact with and connect with prospective permanent parents. Workers engaged in any necessary outreach to connect with distant relatives or people who had not been previously considered.

Second, one of the agencies held trainings for prospective permanent parents. Significant effort was put into structuring the trainings to be as flexible as possible (for example, offering the classes on a rotating schedule so that people could join in at any time). Third, the project included ongoing staff trainings, in part to maintain confidence in their work and belief in its importance. Finally, the project included connecting permanent parents with experienced adoptive parents and providing open support groups for permanent parents.

At its completion, the project succeeded in permanently placing approximately half of the adolescents. This is a remarkably high success rate, given that these were all people living in residential placements or group homes. Avery argues that one of the key elements of its success was the dedication and experience level of the staff, which points to another aspect of interventions with foster care youth (which is beyond the scope of this review but still worth mentioning): To what extent do foster care agencies support staff so that they can avoid burnout and high rates of turnover, which would recapitulate children's experiences of inconsistent and unreliable care?

Senteio, C., Marshall, K. J., Ritzen, E. K., & Grant, J. (2009). Preventing homelessness: An examination of the Transition Resource Action Center. *Journal of Prevention & Intervention in the Community, 37,* 100–111.

In a more concrete example of promoting independent living, Senteio and his colleagues evaluated a program that focused specifically on helping former foster youth develop the skills and experience necessary to maintain an independent household. The Transition Resource Action Center (TRAC) provided three levels of support to emancipated youth. In the first, a majority of the youth's income was saved for him by TRAC as he lived in a supervised apartment with three roommates, with all room, board, and personal needs paid for by TRAC. In the second, less of the youth's income was saved, he was not directly supervised, and personal needs and food were not paid for. In the third, he could live alone, paid according to Section 8 guidelines, and received indirect supervision only if he wanted it. This gradually decreasing support extended over 24 months in total. One limitation of this intervention was that the selection criteria excluded anyone who had "demonstrated assaulting behaviors for 60 days immediately prior to admission" (p. 104); the problem here is that, as discussed earlier, the kids who are aggressive are the ones who are most difficult to help (and therefore most in need of help). As a result of this exclusion criterion, this intervention may not apply to the most at-risk teens. However, it is a positive example of a structured intervention that provides scaffolding in the absence of mentoring from a permanent parent.

Summary

As when considering permanency and stability for adolescents, it may be that we need to reconceptualize what our goals actually are in regard to independent living. When we consider the average experience of an 18-year-old in this society, *interdependence* might be a more fitting term: the adolescent is situated within a web of social supports that he can draw from (or not) as necessary. He has the scaffolding and

safety net necessary to support his growth and protect him from setbacks. Ideally, this would include at least one reliable adult to whom he can turn for mentorship and guidance. The TRAC approach of providing gradually decreasing supports for housing is another model of support.

For further reading:

Antle, B. F., Johnson, L., Barbee, A., & Sullivan, D. (2009). Fostering interdependent versus independent living in youth aging out of care through healthy relationships. *Families in Society: The Journal of Contemporary Social Services, 90*(3), 309–315.

Collins, M. E., Spencer, R., & Ward, R. (2010). Supporting youth in the transition from foster care: Formal and informal connections. *Child Welfare, 89*(1), 125–143.

Greeson, J. K. P., Usher, L., & Grinstein-Weiss, M. (2010). One adult who is crazy about you: Can natural mentoring relationships increase assets among young adults with and without foster care experience? *Children & Youth Services Review, 32*(4), 565–577.

Munson, M. R., & McMillen, J. C. (2009). Natural mentoring and psychosocial outcomes among older youth transitioning from foster are. *Children & Youth Services Review, 31*(1), 104–111.

What interventions reduce risks of violence and delinquency?

Cantos and Gries (2010, see previous citation) found that the children who started out with the most aggressive behaviors were the least likely to improve with therapy, and suggest targeted interventions for kids who match that profile. Because older adolescents can often match adults in terms of physical ability, violence can be difficult to manage, frightening, and even dangerous for foster parents. Finding interventions that can reduce violent and delinquent behaviors might be the most difficult, because they are the most intractable problems, but also the most important, because of their great capacity to disrupt placements and independent living.

Eddy, J. M., Whaley, R. B., & Chamberlain, P. (2004). The prevention of violent behavior by chronic and serious male offenders: A 2-year follow-up of a randomized clinical trial. *Journal of Emotional & Behavioral Disorders, 12*(1), 2–8.

Leve, L. D., & Chamberlain, P. (2005). Association with delinquent peers: Intervention effects for youth in the juvenile justice system. *Journal of Abnormal Child Psychology, 33*(3), 339–347.

A fair amount of evidence has accumulated regarding the efficacy of Multidimensional Treatment Foster Care (MTFC; see the MTFC informational Web site: www.mtfc.com/). Although most of the research appears to have been conducted by one team of researchers, they have attempted to achieve the most rigorous level of experimentation, utilizing a control group and random assignment to maximize internal validity.

One of the real strengths of MTFC is that it combines the intensive treatment of an inpatient or residential treatment setting with the individualized care and family of foster care. In this approach, the foster family is trained, with a particular focus on behavioral interventions, and has weekly meetings, daily phone contacts, and support staff on call 24 hours a day. The youth's treatment plan is individualized and continually adjusted as needed, with an experienced case manager supervising all clinical interventions, conducting the daily phone contacts and weekly meetings, and coordinating among the school, home, and other settings. Because the family is specially trained and intensively supervised, it provides a level of care similar to an inpatient or residential setting; however, because it is a foster family, it does

not put the youth at risk of connecting with other delinquent peers.

Eddy and his colleagues focused specifically on violence, using two measures: official referrals for violence and a self-report measure. Comparing youth randomly assigned to group care ($N = 42$) and MTFC ($N = 37$) over two years, Eddy and his colleagues found a significant difference in both outcome measures. For the official referrals, the only other significant independent variable was prior arrests; for self-reported violence, the only other significant independent variable was prior delinquency.

Leve and Chamberlain focused instead on association with delinquent peers, which has been shown elsewhere to be a predictor of various negative outcomes. They argue that group care has the disadvantage of increasing contact with at-risk peers, thereby increasing the likelihood of maintaining delinquent peer connections and increasing risk of subsequent delinquency and substance use (among other negative outcomes). Once again comparing randomly assigned youth (80 group care and 73 MTFC), the researchers used self-reports and structured interviews with the youth and their caregivers at multiple points over two years. Their research supported their hypothesis, showing fewer deviant peer associations at a 12-month follow-up for the MTFC youth than for the group care youth; however, delinquent peer association declined for both groups following treatment. This is a promising finding, as it suggests that current practices in residential placements are not necessarily iatrogenic. However, the point is still made that the family-type setting of MTFC may be better suited to helping youth establish more adaptive relationship styles.

Huefner, J. C., Ringle, J. L., Chmelka, M. B., & Ingram, S. D. (2007). Breaking the cycle of intergenerational abuse: The long-term impact of a residential care program. *Child Abuse & Neglect, 31*, 187–199.

Violence and delinquency contribute to problematic short-term outcomes, when they interfere with placements; problematic mid-range outcomes, when they result in involvement with the justice system or other negative personal consequences for the youth; and problematic long-range outcomes, when they result in continuing the cycle of violence by introducing it into a new family system. Huefner and his colleagues address the long-range outcome, looking for treatment outcomes in terms of future intimate partner violence.

Huefner and his colleagues examined outcomes of a program based on the Teaching Family Model (TFM). It has some familial aspects, in that a married couple lives in the home with the youth, but it does have a larger number of youth per home than MTFC (up to eight girls or boys per home). It consists of five components: relationship building; interpersonal and life skills, including cleaning and cooking; moral and social development, including weekly religious services; family modeling; and self-government and self-determination.

This research team tracked down 273 of 464 possible respondents who had been in the program in the early 1980s, and 252 of those completed the survey instrument. Though it could be argued that those who are most transient are those who are least likely to have been located, this study did compare nonrespondents and respondents across multiple variables (including aggression and victimization) and found no significant differences. This analysis included only those who were in a committed relationship, resulting in 154 respondents. They also had a comparison group of 23 people who had been referred to the program but did not join it.

The program showed promising long-term outcomes, with the alumni of residential treatment having rates of intimate partner violence similar to those of the general population—unlike the comparison group, whose rates of intimate partner violence were more than three times higher. The

rates of violence were lower for those who had been in the program longer than 18 months as compared to those who had been in the program for less than 18 months. The researchers further disaggregated the residential group by those who had a history of maltreatment, and here they compared rates of violence to the expected rate based on previous research. Those in the program showed rates lower than expected. Also, although it was not statistically significant to separate those with less than 18 months in the program from those with more, those in the program for longer than 18 months showed rates of violence similar to those for the general population.

As mentioned earlier, it is possible that the alumni whom the researchers were able to track down are those who are more stable and generally doing better than those who could not be located. However, even with a history of maltreatment and a high risk for violence, program alumni showed much lower rates than expected, and that effect was more pronounced when they had been in the program longer.

Summary

Both MTFC and TFM show promise in reducing the risks of violent behavior among those with a history of earlier maltreatment. These two approaches have one key piece in common: both emphasize a family-like atmosphere. Even though TFM includes a larger number of youth per home, it is not beyond the number that would be possible in a naturally occurring family arrangement. All the training in life skills and so forth are certainly valuable, but the success of these programs seems to relate to basic principles of self-regulation that people learn from what others model, not what others teach them (Mischel, Cantor, & Feldman, 1996).

For further reading:

Mischel, W., Cantor, N., & Feldman, S. (1996). Principles of self-regulation: The nature of willpower and self-control. In E. T. Higgens & A. W. Kruglanski (Eds.), *Social psychology: Handbook of basic principles* (pp. 329–388). New York, NY: Guilford Press.

What does it all mean?

There have been several successful treatments with adolescents in foster care, and presumably many of the evidence-based treatments for other adolescents with similar problems (aggression, mental health problems, lack of a stable home or family) would also benefit those in foster care. Some particular themes have stood out, however, and bear repeating:

- Regardless of the actual program or intervention used, it should be structured in such a way as to minimize logistical barriers and make it as easy as possible for targeted participants to utilize the treatment. For example, programs can be offered on rotating schedules so that people can join at any time; programs can be offered at multiple locations and transportation can be arranged to simplify getting to the groups; and the hosting site can provide refreshments, child care, and stipends to participants to make it as pleasurable as possible to attend.

- Individualization should also be structured into the intervention. When possible, the interventions should be offered in the participants' native language, and they should be allowed to utilize it in the way that has most meaning for them. An example of this is the child who narrated her trauma using movement rather than words. Also, to maintain the appropriateness of an intervention, there should be constant supervision and adjustment of the treatment plan as necessary.

- Supports should be provided as needed, for as long as needed, with a structured plan for how to gradually decrease supports as the youth

demonstrates competence. The TRAC model of levels of housing support is a nice example of this.

- Finally, and perhaps most importantly, it should be recognized that no individual is truly independent; we all rely on support systems that we have developed over the course of our lives. For an adolescent to be successfully launched out of foster care, she must be launched into a functional support system. One key piece of an adequate, functional support system is a stable adult who can act as a role model and a guide as the youth navigates the transition into adulthood.

Based on these principles, a model such as MTFC and TFM allows multiple specific interventions based on the individualized needs of each youth and the mentorship of stable adults; the ideal would be to build into those models a way to connect each youth with a permanent mentor, as in Avery's (2010) Permanent Parents for Teens program. In the absence of MTFC or TFM, specific training for families in handling the most challenging youth would be valuable, as described in DeGarmo, Chamberlain, and Leve's (2009) study.

Future research directions

Although fostered youth have been the subject of significant research interest, much of the research is still descriptive and does not contribute to developing an evidence base for best practices. However, based on this review, we know enough to provide interventions with confidence that they will benefit the youth. Nevertheless, questions remain; among those that stand out are these:

Diversity. Although Weiner, Schneider, and Lyons (2009) examined outcomes across diverse groups, more work must be done in considering how culture plays into the effectiveness of interventions. The roles of parents and children in the family and in the community vary significantly across cultures, and it stands to reason that disruptions in the family will have a different impact across cultures. We need to be aware that attitudes toward state-sponsored interventions and state employees also often vary by culture, and certainly this will impact effectiveness as well. As discussed by Wells, Merritt, and Briggs (2009), we need to build an evidence base that specifically addresses diversity.

Sensitivity in research. If the evidence base is to be meaningful, it must also include measures of program fidelity, which some studies were more careful about than others. Any study should control for other kinds of variation among the children, beyond cultural diversity, such as age of referral, type of abuse, length of time in care, and number of placements; and it should consider multiple outcomes for interventions. The needs of foster care youth stretch across every imaginable domain, and ideally we would be able to see how the effects of an intervention might ripple across multiple domains (for example, when a mental health intervention also affects education and permanency).

Attention to emerging adulthood. The focus of programs for youth aged 18 and older seems to be primarily on independent living. Though that is certainly important, the research reviewed here reconceptualizes what a positive outcome should look like, and there simply is not any research about what kinds of interventions result in positive, interdependent living outcomes.

Online resources:

Jeffrey Arnett and Emerging Adulthood: www.jeffreyarnett.com

The California Evidence-Based Clearinghouse for Child Welfare: www.cebc4cw.org

Multidimensional Treatment Foster Care: www.mtfc.com/

The National Child Traumatic Stress Network: www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom

The Reach Institute: www.thereachinstitute.org

For further reading:

Wells, S. J., Merritt, L. M., & Briggs, H. E. (2009). Bias, racism and evidence-based practice: The case for more focused development of the child welfare evidence base. *Children & Youth Services Review, 31*(11), 1160–1171.

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