Uncharted Territory: Experiences of Foster Care Youth

Navigating the Mental Health System as they Age Out of Care

by

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ABSTRACT

Youth who turn 18 in the foster care system often face the difficulty of transitioning to adulthood without traditional emotional and financial supports. Early experiences of trauma impact their mental health and receipt of services both while in care as well as decisions whether to continue services after leaving care.

Using the behavior analytic model, this dissertation explores the challenging and supportive situations former foster youth experience with mental health services while transitioning to adulthood. Qualitative interviews and focus groups inform the development of a quantitative instrument in a mixed methods, sequential exploratory research design. The resulting instrument identifies the most intense and frequently encountered situations former foster youth experience, related to their mental health and transitions to adulthood.

Results indicate the most challenging situations foster youth experience during the transition are related to overwhelming expectations, receiving mixed messages from professionals, feelings of isolation, and a lack of voice and choice with regard to mental health services. Young adults in this study also emphasized the importance of responsive engagement, self-efficacy, and consistency in relationships both formally and informally.

This research provides important implications for social work practice, policy, and education. Acknowledging the voice of foster youth gives them a choice in services and allows for realistic transition planning. Developing problem-solving skills and a support network beyond foster care are necessary strategies of preparation to age out. Finally, practitioners should recognize the impact of trauma and other contextual factors when conducting assessment and treatment, to promote positive outcomes.

This dissertation is dedicated to my husband Brent Piel and my parents,

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Chapter 1

INTRODUCTION

The experience of child abuse and neglect can dramatically affect developmental and emotional processes, with the long-term consequences impacting not only the children experiencing maltreatment but also their future relationships, families, and society. In 2013, there were more than 1.8 million cases of child maltreatment in the United States (U.S. Department of Health and Human Services, 2014). Compared to previous estimates, this represents a 23% decline in national child abuse cases during the last ten years. This statistic suggests fewer children are experiencing maltreatment, however the full dimension of the meaning of this reduction remains unclear. The decline in the numbers of service providers, the changes in reporting practices and investigation standards, and a reduction in services due to changing financial and social climates may have led to less reporting or determination of child maltreatment. Of additional concern is local data contradicting these national statistics, with a 24% increase in investigated maltreatment reports in Arizona in the past decade (AZDES, 2014; AZDES, 2002). Also problematic is the number of high risk reports, necessitating an immediate response for safety, which has more than doubled in that time to generate 19% of the 25,076 maltreatment reports in Arizona last year (AZDES, 2014).

As a result of the increased numbers of abuse and neglect cases, as well as the increased severity of cases, it is not surprising that the number of children residing in out-of-home (foster care) placements in Arizona remains higher than the national rates. Nationally, there are 402,000 children in foster care placements, which represent a 23% decline since 2002 (U.S. Department of Health and Human Services, 2014). In Arizona

there are 16,990 children in foster care, which is more than double the number of children in foster placements in 2004 (AZDES, 2014; AZDES, 2002). The high numbers of youth being removed from their biological homes and placed in state custody foster care presents its own set of consequences. Separation from families can be a traumatic experience, compounding the initial trauma experienced from maltreatment. Illustrating the negative impacts of trauma and loss, youth in foster care are two and a half times more likely than their same-age peers to struggle with emotional, behavioral, and educational issues (McMillen, Auslander, Elze, White, & Thompson, 2002).

Literature consistently suggests that childhood adversities can result in emotional distress and the onset of symptoms consistent with mental disorders (Chapman et al., 2004; Kessler, Davis, & Kendler, 1997; McLaughlin et al., 2012). Experiences of child maltreatment and parental maladjustment contribute to later experiences of psychopathology, often with additive effects. Most youth are exposed to at least one childhood adversity, but youth involved in the child welfare system are more likely than their same age peers to experience multiple adversities such as maltreatment, economic hardship, parental substance abuse, domestic violence, and separation from family (McLaughlin et al., 2012).

Older youth in foster care also change placements, schools, and neighborhoods more often, which can contribute to difficulty in relationships and educational achievement. In Arizona, youth in foster care change placements an average of five times before aging out of the system (AZDES, 2014). Beyond changing placements while in the system, 66% of youth who enter the system at age 12 or older are more likely to leave care due to reaching the age of majority or emancipation, rather than due to

adoption, reunification, or guardianship (U.S. Department of Health and Human Services, 2013). Inconsistent placement changes and independent living case plans may contribute to compounding issues of emotional and behavioral adjustment, when considering that older youth have likely faced challenging circumstances years prior to child welfare intervention and out-of-home placement (Courtney & Heuring, 2005).

The difficulties youth have faced prior to as well as in foster care likely contribute to outcomes after they leave the system and transition to adulthood. Nationally, more than 25,000 youth in foster care reach the age of majority and "age out" of the foster care system each year (U.S. Department of Health and Human Services, 2014). In Arizona, more than 800 youth aged out of foster care system last year (AZDES, 2014). Experiences of maltreatment and system involvement compounded by the transition to independent living and adulthood can be especially difficult for youth in foster care who likely have less social, emotional, and financial support (Avery, 2010; Collins, Spencer, & Ward, 2010) than children not in foster care. Youth aging out of foster care are more likely than their same age peers to experience educational abandonment, victimization, justice system involvement, unemployment, and homelessness, as well as issues with health and mental health (e.g. Barth, 1990; Courtney & Dworsky, 2006; Havlicek, Garcia, & Smith, 2013; Fowler, Toro, & Miles, 2011; Pecora, et al., 2006).

In addition, these youth are more likely than their same age peers to be parenting at an early age and to have their own children involved in the child welfare system (Dworsky & DeCoursey, 2009; Marshall, Huang, & Ryan, 2011). Young adults with impaired psychological functioning may become parents who then have trouble providing developmentally appropriate and responsive care to their children (Kotch et al., 1995),

and parents with a history of maltreatment who are also struggling with psychological distress may be at higher risk than other parents of abusing or neglecting their children (Dixon, Browne, & Hamilton-Giachritsis, 2005; Marshall et al., 2011). Youth face emotional and behavioral challenges as they age out of the foster care system and transition to adulthood, however minimal research has explored such challenges from the youth's perspective to determine the intensity of such problems and strategies to address mental health needs during the transition.

A critical point of intervention in preventing future child abuse and neglect may be during the transition to adulthood, when youth in foster care are making independent decisions about their mental health. Likely a result of traumatic experiences of abuse and neglect, youth involved in the foster care system have an increased likelihood of developing behavioral and emotional problems relative to youth of comparable backgrounds. Research estimates vary considerably, but range between 37% and 80% of youth in child welfare systems diagnosed with psychiatric disorders, as compared with only 10% to 26% of the general population (dos Reis, Zito, Safer, & Soeken, 2001; McMillen et al., 2005; Merikangas et al., 2011; Raghavan et al., 2005; Zima et al., 2000).

As youth near the transition to independent living and aging out of the foster care system, exposure to stress increases, especially for youth who have less than adequate support systems. In addition, foster youth with unstable living situations are three to four times more likely to be diagnosed with an emotional or behavioral disorder, as compared to foster youth living in stable situations (Fowler, Toro, & Miles, 2009). Older youth in foster care have particularly high rates of meeting criteria for psychiatric disorder, with more than 60% meeting criteria for at least one psychiatric diagnosis (McMillen et al.,

2005; Pecora, White, Jackson, & Wiggins, 2009) and 23% meeting criteria for three or more disorders (Pecora et al., 2009).

Although mental health symptoms among foster youth often continue after they age out of care (Pecora et al., 2009), mental health service utilization decreases dramatically (Courtney et al., 2011; McMillen & Raghavan, 2009). Longitudinal studies that measured mental health service use at ages 17 and again at ages 19, indicate that psychotherapy and medication rates drop by nearly 50% (Courtney et al., 2001; Courtney et al., 2005). McMillen and Raghavan (2009) found that within 6 months of aging out of the foster care system, outpatient psychotherapy and medication use declined by 60%. After leaving care, 68% of these young adults reported making the decision to discontinue medications without medical guidance, because they either did not like being on the medication or did not believe it was needed (McMillen & Raghavan, 2009). Other studies have identified cost and lack of insurance as barriers to receiving mental health care after aging out (Courtney et al., 2005; Kruszka, Lindell, Killion, & Criss, 2012). Most pediatric and adult mental health systems lack shared client planning, and the requirements in adult systems are typically more stringent, which increases the difficulty in transition between systems (Christian & Schwartz, 2011; Davis & Sondheimer, 2005). Although there are obvious systemic barriers to accessing and maintaining mental health services, it is unclear from these studies how youth perceive these barriers, more specifically what influences their decision-making process.

Understanding how youth experience mental health services as they age out of care provides social workers and other mental health professionals important insight regarding how to create systems that increase the likelihood of positive mental health

outcomes for this population. The reduction in service utilization suggests youth are either unsatisfied with current services or may be encountering barriers in meeting their mental health needs during the critical phase of transition. It is also possible that there are supports or strategies that youth have found helpful as they navigate mental health needs into adulthood, including those who do not involve traditional mental health service utilization. Larger, longitudinal studies previously conducted with youth aging out of foster care offer general reasons for discontinuation of services and will be described in greater detail in the literature review section of this dissertation (Courtney, Terao, & Bost, 2004; McMillen et al., 2004; Pecora et al., 2003). Although these studies provide important information including rates of service utilization and reasons for discontinuation, they are limited in their ability to offer an in-depth description about the decision-making process from the perspective of the emerging adults themselves. Seeking information from the stakeholders themselves allows deeper understanding about the transition from foster care and pediatric mental health systems into adult systems and responsibilities, which is a critical point of intervention for improving outcomes and preventing child maltreatment in future generations.

The proposed research study aims to answer the question: As youth age out of foster care, what perceived barriers and strategies exist for meeting their mental health needs? Specifically, this study aims to (a) explore the self-identified mental health needs of youth as they age out, (b) identify problem situations youth encounter in meeting these needs, (c) identify strengths and supports youth find helpful, and (d) determine the most frequent and difficult barriers and strategies encountered by this population when navigating the adult mental health system.

Chapter 2

LITERATURE REVIEW

Despite recent reports of declining numbers of child abuse cases in the last decade (U.S. Department of Health and Human Services, 2014), child maltreatment continues to be a substantial public concern with studies associating it with negative developmental outcomes and psychopathology (Kaplow & Widom, 2007; McLaughlin et al., 2012). The experience of child maltreatment has the potential to create behavioral and emotional difficulties that profoundly affect a child's development and life course well into adulthood and affecting future generations. Youth in child welfare systems often receive services to address these emotional and behavioral needs, yet psychosocial outcomes for youth who remain in the system until their 18th birthday remain poor (e.g. Courtney et al., 2011; Pecora et al., 2009). Complex interactions of the developmental and emotional consequences associated with childhood maltreatment as well as abrupt societal expectations of independence and autonomy associated with reaching the age of majority are likely compounded by the fragmentation of services between pediatric and adult systems. Understanding the mental health needs and process of decision-making during the transition may provide insight into struggles and effective supports which may promote successful outcomes for this generation as well as prevent maltreatment in future generations.

Contemporary Mental Health System

The experiences of mental health services for youth aging out of foster care may best be understood by first exploring the underlying assumptions of the contemporary mental health system through which services are offered. Psychiatric diagnosis and drug

treatment have long been based on the biomedical model, asserting that mental disorders are caused by biological abnormalities in the brain as a result of disease or defect in brain structure or function (Andreasen, 1984). The model provides an explanation of mental disorders that avoids blaming bad habits, poor parenting, or emotional weakness, which may theoretically lessen some of the individual and social stigma that often accompanies diagnosis of mental disorder; however, there are data demonstrating that bioreductionism actually increases prejudice and stigma in other areas that inhibit recovery (Kvaale, Haslam, & Gottdiener, 2013; Read, 2007).

The biomedical model has become more popular in clinical social work in the past 30 years, with practitioners often promoting psychoeducation based on the disease model and encouraging adherence to medication; however, there are also studies demonstrating attention to psychosocial influences. Rubin and colleagues (1998) found that even when 87% of clinical social workers and students agreed with the biological etiology of mental disorder, 71% also agreed with parental and family responsibility and treated with considerations to both. Strict reliance on environmental causes could also be harmful, blaming family dysfunction and potentially exacerbating symptoms (Rubin et al., 1998), however failure to acknowledge how these factors influence mental disorder may also cause harm by overlooking potential sources of intervention. Mental disorder is obviously not as dichotomous as either biological or psychosocial in etiology, but there is a need to critically examine the evidence-base and validity of both approaches to social work practice.

Certainly there are people who report successful symptom relief with psychiatric medication use, but there is also evidence that simply being treated can offer a sense of

hope and promise of relief from their distress (Fournier et al., 2010; Kirsch, 2010). This sense of hope or belief in efficacy has been demonstrated with studies and reviews of placebo effects. Kirsch and colleagues (2008) reviewed drug efficacy data from double-blind randomized trials submitted to the U.S. Food and Drug Administration (FDA), finding the mean difference between the drug and placebo effects to average less than two points on the Hamilton Depression Rating Scale, or no clinical difference. Fournier and colleagues (2010) found similar results in their meta-analysis of six placebo-controlled trials, corroborating that patients with mild or moderate symptoms experienced minimal, if any symptom improvement. Other researchers have reviewed published and unpublished data on SSRI's for treatment of childhood depression, finding no clear evidence of benefit overall, but rather a small increased risk of suicidal ideation and serious adverse effects (Whittington et al., 2004).

Neuroimaging has also been claimed to provide evidence to support the biomedical model, yet there is no definitive research in this area. Rubenstein and Anderson (2011) claim, "there is increasing evidence that abnormalities in the development of the brain either predispose or directly cause certain psychiatric disorders" (p. 3), yet the neuroimaging studies to support the causation of attention deficit hyperactivity disorder (ADHD) and pediatric bipolar disorders (PBD) in subsequent chapters, cautiously state that they provide limited understanding and only preliminary conclusions can be drawn (Plessen & Peterson, 2009; Liebenluft, 2009). The National Institute of Mental Health (NIMH; National Institute of Mental Health, 2013) also states that extensive research has been conducted with neuroimaging to delineate which areas of the brain function in cognition and how changes in the brain can be detected to support

behavioral changes and mental disorder. They acknowledge that “neuroimaging cannot be used alone to diagnose mental disorder,” but then assert educational materials on the “science of mental illness,” for which brain scans can help in detection and diagnosis (National Institute of Mental Health, 2013, p. 1). The conflicting statements in both academic textbooks as well as from the national funder of mental health research are misleading for both researchers and practitioners. Delineating areas of the brain from which abnormalities in behavior can be explained would clearly support the biomedical model of psychiatry, however, there is not specific evidence in which neuroimaging has been able to make such confirmations or predictions (Frances, 2013; Leo, 2004). One must also consider the plasticity of the brain, in which changes occur not only during early childhood but also throughout the lifespan (Banich, 2004). The brain experiences continuous synaptogenesis in response to exposure and experience.

Reliability and validity of childhood diagnoses. The National Comorbidity Survey estimates that 46% of the U.S. population has met criteria for a diagnosable mental disorder in their lifetime and 26% (nearly 82 million people) meet criteria in any given year (Kessler & Wang, 2008). The Diagnostic and Statistical Manual (DSM) for mental disorders provides common language for recognizing and naming abnormal patterns of behavior; however its reliability of psychiatric diagnosis has been challenged for lack of clear boundaries and variety of interpretations (Jensen & Mrazek, 2006; Kirk & Kutchins, 1992). Concepts of clinical significance and medical necessity are difficult to operationalize and the determination of severity or impairment is often arbitrary (Jensen & Mrazek, 2006).

Even DSM-V field trials conducted at pediatric sites across the United States

demonstrated poor reliability in the degree to which two clinicians could independently agree on the presence of absence of diagnosable symptoms, especially for diagnoses more common in middle childhood and adolescence. For example, kappa values for oppositional defiant disorder ranged from .40 to .59, however major depressive and dysregulation disorders were only .20 to .39, indicating clinicians did not agree on a diagnosis 70 to 80% of the time based on the DSM criteria. Mixed anxiety-depressive disorder and non-suicidal self-injury had kappa values less than .20 (Regier et al., 2013), and accurate estimates of kappa for bipolar, PTSD, and conduct disorder were considered unsuccessful by the researchers due to sample size (Regier et al., 2013).

Even if research could support the reliability of diagnosis through the DSM, there also remains the question about practitioner adherence and subjectivity, which can impact whether a child receives a mental health diagnosis and treatment. Bruchmuller, Margraf, and Schneider (2012) assert that clinicians do not strictly adhere to diagnostic criteria and are influenced by biases and representative heuristics when making diagnoses. Nearly 17% of clinicians diagnosed ADHD in vignette cases that did not meet DSM criteria for diagnosis, and clinicians were twice as likely to diagnose ADHD with males who presented identical symptoms as females in the vignettes (Bruchmuller et al., 2012). In another vignette-based study of conduct disorder diagnoses, contextual factors of the clinician such as occupation and age affected rates of diagnosis; psychiatrists were more likely than both psychologists and social workers to diagnose even when symptoms of the disorder were not present, OR= 4.62, 95% CI [2.99, 7.14], and older professionals were less likely to diagnose, OR = .80, 95% CI [.65, .98], (Pottick, Kirk, Hsieh, & Tian, 2007). Both examples utilized vignette studies, which can only approximate clinical

settings, although they still provide insight into factors influencing diagnosis.

Additional screening instruments such as the Child Behavior Checklist and Youth Self Report scales (CBCL; Achenbach & Edelbrock, 1983; YSR; Achenbach, 1991) are widely used for clinical and research purposes to classify behaviors and social competence. To enhance comparison of the CBCL and YSR scales with the DSM-IV, the scales were updated in 2003 by surveying mental health professionals from 16 countries, who agreed at least 64% of the time in rating items as being "very consistent" with diagnostic categories (Achenbach, Dumenci, & Rescorla, 2001). Some research has supported the convergent validity of the DSM-oriented scales (Nakurmara, Ebesutani, Bernstein, & Chorpita, 2009); however other studies have questioned the same validity and the ability of the CBCL/YSR scales to predict DSM diagnoses. Research examining the youth self-report (CBCL/YSR DSM-IV) scales with Dutch adolescents found that symptoms of major depressive disorder corresponded more closely with the YSR scales for affective problems ($r = .67$) than with either the YSR anxious/depressed ($r = .58$) or withdrawn/depressed syndrome scales ($r = .55$) (van Lang, Ferdinand, Oldehinkel, Ormel, & Verhulst, 2005). Ferdinand (2008) also demonstrated that the CBCL and YSR anxiety problem scales poorly predicted DSM-IV anxiety disorders (AUC =. 61-.63) in a similar population of Dutch adolescents (.5 - .7 scores are considered poor in ROC analysis). Even Achenbach and colleagues (2001) admit "the associations that are found between diagnoses and scale scores may vary according to the training and orientation of the diagnosticians, the diagnostic procedures, the ages of the children, the sources of data, and other factors" (p. 1).

Treatment. Concerns with lack of reliability and validity of psychiatric

diagnosis, naturally lead to concerns of the clinical consequences and effects of treatment. Although multicomponent programs seem best framed to address the mental health needs of youth, including consideration to contextual and developmental factors (Cameron et al., 2001; Holmbeck, Devine, & Bruno, 2010), psychiatric medication often remains a first-line method of treatment. Thomas, Conrad, Casler, and Goodman (2006) report rates of mental health office visits which resulted in psychiatric medication prescription increased from 3.4% to 8.3% from 1994-2001, or an increase of nearly 2 million children and adolescents. Olfson, Blanco, Moreno, and Laje (2006) used the same national survey data to report 9.2% of children and adolescents were prescribed antipsychotic medications and only 36% of those prescribed antipsychotics also had psychotherapy. Timimi (2004) argues that change in western cultural structures and lifestyles have contributed to over diagnosis of childhood disorders, which pushes psychotropic medication prescription rather than focusing on the social contextual factors involved.

The numbers of youth on disability due to serious mental illness has risen dramatically in the past 20 years, from 65,040 (1994) to 781,795 (2013; Social Security Administration, 2014), which suggests that increased use of psychiatric medications has not resulted in improved aggregate long-term outcomes. There are clinical studies supporting short-term use of psychiatric medications to reduce symptoms associated with childhood mental disorders (e.g. Drilea et al., 2013); however, there is a paucity of longitudinal studies demonstrating improved long term outcomes. Examining the adverse effects and long-term risks of psychiatric medication use indicates that the long term use of psychiatric medication is associated with metabolic abnormalities such as

weight gain, high cholesterol, and insulin resistance (Calarge, Acion, Kuperman, Tansey, & Schlechte, 2009; Jerrell, 2010). In one study, 34% of the children and adolescents taking risperidone, on average for three years, were either overweight or obese (Calarge et al., 2009). The odds of having at least one metabolic abnormality such as higher insulin resistance or cholesterol was nearly 12 times for the overweight/obese youth, OR = 11.5, 95% CI [3.3, 40.5], (Calarge et al., 2009). Another study of children and adolescents reports that weight gain and type two diabetes were more likely in children and adolescents prescribed selective serotonin reuptake inhibitors (SSRIs) than those who were not prescribed antidepressants, OR = 1.34, 95% CI [1.17, 1.54] and OR = 1.37, 95% CI [1.10, 1.71], respectively

In addition to adverse effects of individual psychiatric medications, many youth are prescribed concomitant or multiple medications, which present additional risks. Zito and colleagues (2008) concluded that youth in foster care often receive the same psychiatric treatment regardless of diagnosis, and multiple medications from concomitant medication classes are often being prescribed. More than 40% of youth in the study were prescribed at least three different classes of psychiatric medications, most of which did not have current labeled indication by the FDA (Zito et al., 2008). Although the FDA regulates drug approvals, it does not regulate prescribing. Off-label medication prescriptions for children are common, however many people are not aware they are receiving an off-label medication.

The prescription of multiple psychiatric medications for children is especially concerning when considering the evidence that psychiatric medications may be contributing to the development of more serious symptoms and disorders (Whitaker,

2010). For example, the FDA issued a statement in 2006 regarding psychiatric adverse events resulting from stimulant medication use: that "signs and symptoms of psychosis or mania, particularly hallucinations, can occur in some patients with no identifiable risk factors, at usual doses of any of the drugs currently used to treat ADHD" (Gelperin & Phelan, 2006, pg. 3). A review of service and pharmacy data for more than a million youth in the U.S. indicated that many youth had previously been diagnosed with depressive disorders (46.5%), disruptive behavior disorders (36.7%), and ADHD (27.2%) and prescribed antidepressants (48.5%) stimulants (33.0%), mood stabilizers (31.8%) or antipsychotics (29.1%), the year prior to receiving a new diagnosis of PBD (Olfson, Crystal, Gerhard, Huang & Carlson, 2009). Geller, Zimerman, Williams, Bolhofner, and Craney (2008) also reported that half (48.6%) of the 72 children in their original study who were prescribed antidepressants for major depression, were now diagnosed with bipolar disorder as adults.

The relationship between treatment and diagnosis is complex and more data are needed to draw stronger conclusions. For better or worse, the contemporary mental health system drives services available for youth aging out of foster care. Discrepancies and inconsistencies in psychiatric diagnosis can impact treatment as well as long-term outcomes. Practitioners must maintain an informed but critical stance in issues related to mental health systems and services. The adverse effects and iatrogenic harm that can be caused by such treatment should be carefully considered even in combination with psychotherapy. Whether service utilization is positive may not be the primary question in our ability to meet the mental health needs of youth aging out of the foster care, but rather what are the experiences and process of decision-making related to services and meeting

their self-identified mental health needs. Considering the potential for adverse effects and the possibility that youth discontinue mental health services due to dissatisfaction with services, understanding more about foster youth's experience with mental health services seem important. Understanding their experiences of diagnosis, treatment, adverse effects, and service utilization may provide insight into issues of the current mental health system as it affects this particularly vulnerable population.

Adolescent Mental Health

Adolescence is a period of significant cognitive and physical development, where the capacity for abstract thought and socio-emotional competencies are refined. The development of identity, moral judgment, empathy, and prosocial behavior are all tasks that are impacted by where the adolescent is developmentally, which needs to be taken into account in research and practice (Holmbeck et al., 2010). The developmental period of adolescence has progressively expanded in the U.S., with puberty now beginning as early as nine or ten years of age (Parent et al., 2003), and on the opposite end transitions associated with emerging adulthood, such as full-time employment and significant relationships, are occurring well into the late twenties (Arnett, 2007). Adolescents are likely in different stages even within this developmental period, which affects assessment, treatment, and outcomes.

Developmental considerations. DSM classifications for childhood disorders have been based on adult mental disorders and therefore lack the consideration of the more dynamic child and adolescent development and trajectories of functioning in diagnosis. Jensen and Hoagwood (1997) assert that diagnoses of children and adolescents cannot be considered without attention to development and processes

concluding that "meaningful outcomes can no longer be captured by an exclusive focus on signs and symptoms. Instead, adaptive functioning, the nature of the surrounding environments, and the relationships between organism and environment become critical areas for assessment" (p. 239). It is also important to consider normative behaviors for adolescence as the degree to which problematic externalizing behaviors can change. Youth also act out for a variety of reasons, including reactions to traumatic events, but also for reasons such as loss of control or uncertainty of their current situation. Hyde and Kammerer (2009) interviewed 20 adolescents with maltreatment histories and placement instability; youth expressed difficulty in behaviors and maintaining placements due to forced changes in placement, unrealistic expectations, false promises from adults, and general uncertainty in family circumstances.

In addition, diagnosis of children and adolescents needs to consider where information is obtained and combination of information from multiple informants. For example, a child may meet diagnostic criteria based on a parent's report of symptoms but not their own or vice versa. From a sample of over 1200 pairs of parents and children, Jensen et al. (1999) report that children and adolescents self-identified more diagnostic criteria consistent with major depression and dysthymia than their parents, $\chi^2 = -7.4$, $p < .01$, and more parents identified diagnostic criteria consistent with oppositional defiant disorder (ODD) and ADHD than their children, $\chi^2 = 20.6$, $p < .01$ and $\chi^2 = 11.4$, $p < .01$, respectively. The reliability and motivations for diagnosis should be considered from all informants as well as the weight given to information from multiple informants in assessment.

The literature consistently links childhood adversities to the onset of mental

disorders. A national survey of adolescents determined that more than half of adolescents (58.3%) experience at least one childhood adversity, and about the same percentage of these youth (59.7%) are experiencing an average of 3.2 (*SD* = .1) adversities in childhood (McLaughlin et al., 2012). Childhood adversities can take many forms such as family economic hardship, loss of a parent through divorce, death, and separation. Those most strongly associated with the onset of psychiatric disorders are childhood adversities specific to family maladjustment such as physical and sexual abuse, neglect, parental mental disorder, and family violence (McLaughlin et al., 2012). Chapman and colleagues (2004) also report that emotional abuse, physical abuse, sexual abuse, and family violence increased the likelihood of depression diagnosis in the last year, OR = 3.1, 95% CI [2.6, 3.8], OR = 2.3, 95% CI [2.0-2.7], OR = 2.0, 95% CI [1.7, 2.3], and OR = 2.2, 95% CI [1.8, 2.7]), respectively. Although these studies were retrospective in nature, which is limiting due to recall bias, they provide useful grounding that many adolescents experience childhood adversities which can affect their mental health, and it appears that issues with maltreatment and violence also predict higher incidences of psychopathology.

The age of onset of child maltreatment and mental disorders also seems to affect outcomes in adulthood. Kaplow and Widom (2007) followed a sample of 496 children who had court-substantiated cases of child maltreatment prior to the age of 11, until approximately age 40. Although the study only utilized two follow-up interviews into adulthood, the results suggest that children who experience first onset of maltreatment before age 5 had higher symptoms of anxiety (β = -.21, $p < .05$) and depression (β = -.20, $p < .05$) as adults, while children who experienced the onset of maltreatment just before adolescence were more likely to meet diagnostic criteria for antisocial personality

as adults (OR = 5.32, $p < .05$). Roisman, Aguilar, and Egeland (2004) also evaluated data from a longitudinal study of children born in low-income neighborhoods, concluding that individuals who expressed conduct issues and antisocial behaviors prior to 7th grade were more likely to exhibit continued antisocial behavior in adulthood, than those with adolescent onset of such behaviors, $\chi^2(2, n = 56) = 9.07$. In addition, children who expressed early antisocial behaviors were more likely than adolescents to show problems across all adjustment areas at age 23, including higher levels of illicit drug use, lower levels of academic attainment, higher levels of life stress, and poorer vocational adjustment (Roisman et al., 2004). The populations in these studies differ, but both suggest that earlier onset of childhood adversities and/or mental disorder contributes to continued impairment in adulthood. Unfortunately, the results cannot directly explain the mechanism and variables such as supportive relationships, social capital, and individual resiliency in adolescence which could have also impacted such outcomes.

Service use. Adolescent mental health assessment and outcomes in adulthood are likely impacted by availability and use of mental health services. A national survey of nearly 6500 adolescents revealed that only a 36.2% were receiving mental health services for a diagnosed mental disorder, most often through mental health specialists (35.4%) or school services (35.4%) (Merikangas et al., 2011). In addition, Hispanic adolescents were less likely than their Caucasian counterparts to receive treatment for mood and anxiety disorders, and African-American adolescents were less likely to receive services for mood disorders, OR = .47, 95% CI [.29, .78], OR = .24, 95% CI [.09, .65], and OR = .23, 95% CI [.14, .40], respectively (Merikangas et al., 2011). There are clearly complex issues related to service utilization, including possible systemic barriers related to access

and culture. Consideration must be taken when youth are looking to seek help but find themselves amidst a fragmented system of care. Stroul and Friedman (1986) conclude that systems of care for emotionally disturbed youth consist of seven major dimensions: mental health services, social services, educational services, health services, vocational services, recreational services, and operational services. Ideally, there would be communication and strong relationships between all components in order to provide integrated care. Hoagwood (2005) argues that these systems are governed by differing policies and structures, which make it nearly impossible to coordinate care and adequately.

Assessment and classification lead to treatment plans. Therefore it is also relevant to note that comprehensive reviews of adolescent psychotherapies suggest that many psychosocial treatment programs for adolescents are modifications of adult-based or child-based treatments rather than considering specific developmental needs of adolescents (Weisz & Hawley, 2002). In a review of empirically-supported psychotherapies used with children and adolescents, Weisz and Hawley (2002) propose that only 14 evidenced effective outcomes with adolescents with medium to large effects, of which seven were downward adaptations from treatments originally designed for adults and six were upward adaptations from children's treatments. Considering the previous discussion promoting developmental considerations in assessment, it is equally concerning that more treatments are not developmentally sensitive to meet the behavioral, psychological, and social needs of adolescents.

In terms of psychiatric medication, adolescents may understand treatment of mental disorders from a different perspective than adults. Floersch et al. (2009)

interviewed 20 adolescents diagnosed with at least one mental disorder, for which they were taking an average of 2.35 (*SD* = 1.09) medications. When asked how medication worked, many reported that it helped them to sleep, "to act right," and "to do stuff better"; they also described hope for medications to "provide a cure," control their anger," or "relieve stress" (Floersch et al., 2009, pg. 164). Lack of adherence to medications was reported by adolescents as due to adverse effects experienced, difficulties remembering to take it, or worrying about dependency; conversely, youth were likely to continue taking psychiatric medications as prescribed when noticing improvements in family, peer, and school relationships and emotional stability (Floersch et al., 2009). Youth in this study believed medications would help control behaviors and improve relationships with friends and family, which presents an interesting perspective to consider in treatment by psychiatric medications. Consideration of informed consent and realistic motivations for taking medications is important, as well as understanding that youth may be more focused on the social aspect and stigma of behaviors related to mental health and disorders.

Adolescence represents a critical shift in decision-making for youth as they learn to navigate social situations and gain increased independence. Ungar and Teram (2000) studied adolescents' feelings of psychological empowerment-related to mental health and services. Forty-one youth with multiple biopsychosocial risk factors of poverty, parental mental disorder, experiences of maltreatment, family violence, and mental disorder of their own were interviewed about their understanding of mental health and how they see positive outcomes despite difficult circumstances (Ungar & Teram, 2000). Participants reported their interpretation of mental health around the need personal and social

empowerment; they also emphasized the idea that they wanted to be seen as regular youth, not as dysfunctional or as a victim (Ungar & Teram, 2000). The stigma attached with being "at-risk" or having a mental disorder likely effects feelings of self-worth and the likelihood of continuing to engage in services others may view as part of their "dysfunction." The sample was primarily drawn from an author's private practice, but still provides insight into relationships and motivations behind decision-making that can help build future research.

In terms of initially seeking help for mental health issues, stigma is a central concern for many young adults with mental health issues and can impact help-seeking. Even though biomedical beliefs and diagnostic labels are intended to help the public view mental disorder as a medical condition, research indicates such beliefs actually increase negative associations and social distance from those with mental health issues (e.g. Read, Haslam, Sayce, & Davies, 2006). Experiences of stigma can impact seeking help, especially for men. A school-based survey of more than 11,000 Norwegian adolescents reports that even at the highest symptom levels on the Hopkins-Symptom Checklist (HSCL-10) for anxiety and depression, only 34% of youth reported help-seeking in the last year (Zachrisson, Rödje, & Mykletun, 2006). Those youth who did seek help, typically chose a psychiatrist or psychologist (39.8%) or medical doctor (44%). The HSCL-10 limits screening to only anxiety and depression, based on a self-report of ten questions, which is short as well as does not address externalizing behaviors which may have prompted more help-seeking.

In the U.S., Timlin-Scalera, Ponterotto, Blumberg, and Jackson (2003) interviewed 35 affluent Caucasian adolescents to identify mental health stressors and

strategies or factors influencing decisions related to seeking psychological help. Young men reported the pressure to fit into their social environments, within social groups, and the community; they also feared being labeled "weak" or "troubled" and expressed concerns about confidentiality in a small community (Timlin-Scalera et al., 2003). Young women and reported similar stressors but felt the pressure was higher for their male counterparts, who would be less likely to seek help and do not recognize when they have a problem for which they need help. For those willing to seek help, adolescents were more likely to seek help from informal sources such as parents or family (Timlin-Scalera et al., 2003).

Adolescents seek help when they feel "emotionally competent" and that they are part of the decision-making and service delivery (Ungar & Teram, 2000). Adolescents who feel that they have some control over their mental health services and how others view their mental health-seeking, may be more likely to engage in services. It is also possible that youth with self-efficacy are likely to find additional, non-service related supports as strategies to help them manage emotional and behavioral health issues. Finding a way to incorporate developmental and environmental factors to increase access to services is important; however, service utilization is a choice and not the only option for youth with emotional and behavioral difficulties. Adolescence is a critical transitional period, marked by significant changes in biological, psychological, and social realms within which youth must adapt. This period theoretically presents great opportunity for prevention and treatment of psychopathology and for the promotion of positive emotional and behavioral functioning. As youth transition to adulthood and begin making more independent decisions regarding their mental health, it is important for researchers and

practitioners to understand the decision-making process and what supports youth find effective in meeting their mental health needs.

Mental Health of Youth in Foster Care

National survey data on youth in child welfare suggests that nearly half (47.9%, 46.8%,) of children in the child welfare system have clinically significant emotional or behavioral issues, likely a result of traumatic experiences of maltreatment (Burns et al., 2004; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). Trauma affects individuals differently, however repeated exposure to traumatic events has been linked to low academic performance, difficulties in relationships, and engaging in high-risk behaviors (e.g. Cicchetti & Toth, 1995; McLaughlin et al., 2012). Disruptions in early developmental stages can have enduring implications across the lifespan. Cicchetti and Toth (1995) suggest that disruptions in the development of attachment, adaptation to school, and externalizing or internalizing behaviors can all contribute to the development of psychopathology. Contrasting the biomedical model, the model of developmental psychopathology takes into account transactions between the child's biological and psychological characteristics and the environment in which they live (Cicchetti & Toth, 1995). Outcomes such as behavioral disturbances and psychopathology are considered a result of negative transactions and risk factors.

Although preventing the placement of children in out of home foster care and minimizing their length of stay are child welfare priorities, the average length of stay in foster care is 22.7 months (U.S. Department of Health and Human Services, 2013). Youth in foster care face additional challenges related to separation from family, disruption from friends and school, as well as stigma of being in care which can impact

their mental health. Ellermann (2007) conducted focus groups with 32 former foster youth, foster parents, and social service professionals, and found that ongoing stress from current life situations, frequent placement changes, a desire for autonomy, normalcy, and connection were important factors in mental health for foster youth. Developing self-protective coping strategies to handle feelings of uncertainty or powerlessness, as well as deliberate misbehavior were often ineffective and destructive, and contributed to either internalization or externalization of behaviors, respectively (Ellermann, 2007). Inappropriate coping skills, internalization, and externalization are commonly identified predictors of diagnosable mental disorders; research indicates earlier experiences of maltreatment predict more symptoms of anxiety and depression, while later onset of maltreatment was predictive of more conduct-related issues (McLaughlin et al., 2012).

Medications. From 1987 to 1996, Zito and colleagues (2003) found that psychiatric diagnosis and medication prevalence rates in Medicaid-insured youth nearly tripled, reaching similar utilization rates as adults. The number of Medicaid-insured youth again tripled in diagnoses and medication rates by 2006, this time surpassing the increases of adults (Zito, Burcu, Ibe, Safer, & Magder, 2013). Recent estimates of 15% to 40% of youth in the child welfare system are prescribed psychotropic medications (Leslie et al., 2011; McMillen et al., 2005; Naylor et al., 2007; Raghavan et al., 2005) as compared to estimate of 4% to 20% of the general youth population (O'Connell, Boat, & Warner, 2009; Olfson, Marcus, Weissman, & Jensen, 2002). Prevalence studies are difficult to compare due to methodological variations in population, inclusion ages, children or adults reporting symptoms, and methods of analysis; however, they can provide trends of concerning issues to explore further.

As the rates of prescription have increased, more attention has been placed on the safety and efficacy of these medications for children (Breland-Noble et al., 2004; Zito et al., 2003). As previously mentioned, there is concern about the long-term adverse effects of medication use (Whitaker, 2010). Research has also found that helping professionals hold mixed views of psychotropic medication use with youth, but generally support its use as part of a more comprehensive treatment plan (Moses & Kirk, 2006). A survey of clinical social workers treating adolescents ($N = 563$) provides that 81% of clinicians view medications as necessary components of treatment; however, only 9% felt that medications were the most effective way to address adolescent behaviors (Moses & Kirk, 2006). Most (88.8%) agreed that psychiatric treatment should not be used as the first line of treatment and some (15.5%) believed the medications even made youth more disturbed (Moses & Kirk, 2006). Although this study represents only the opinions of clinicians, the respondents' average experience was 20 years post-master's degree and 88% reported having specific training or education in psychopharmacology, suggesting substantial practice experience with the population.

There is also concern that psychiatric medications are prescribed to youth as a behavioral control rather than to reduce symptoms of mental disorders. In the previous study, two-thirds (67.2%) of clinicians felt that medications were often used as a substitute for other treatment (Moses & Kirk, 2006). Observations of youth on methylphenidate depict diminished hyperactivity and impulsivity as intended, but they also depict youth with flat affect and apathetic attitudes, who were socially withdrawn and generally subdued (Manos et al., 2011). This also presents a practical issue for youth in foster care, as youth demonstrating externalizing behaviors such as aggression and

irritability are more likely to experience placement disruption (Farmer, Lipscombe, & Moyers, 2005). Although there are concerns regarding using medications as behavioral control, there are also real implications related to the need to provide stable, placement for foster youth, and controlling youth's behavior may lead to increased placement stability.

Opinions seem to be less mixed related to polypharmacy, however prescription of multiple medications is a common occurrence in foster care. Zito and colleagues (2008) assert that most foster youth are prescribed two or more medications and multiple medication classes were being prescribed for the same psychiatric diagnoses. Additionally, youth in the foster care system in Arizona change placements an average of seven times during their involvement with the child welfare system (AZDES, 2012). This increased mobility in placements supports a discontinuity in service provision as well as inconsistent medication management. It has been suggested that in these situations of increased mobility, there is a lack of a "consistent interested party" to establish and manage treatment over time, which may be a factor leading to increased multiple medication prescriptions (Naylor et al., 2007, p. 179).

In addition to higher occurrences of mental health services and medication prescription, older youth in the foster care system represent a unique population due to their increased likelihood of out-of-home placement and eventual transition from foster care to independent living when they reach the age of majority at 18 (Montgomery, Donkoh, & Underhill, 2006). James, Landsverk, Slymen, and Leslie (2004) suggest that more placement changes were related to increased mental health service utilization in an outpatient setting. Changes in placements may be due to the youth's behavior problems

or simply as a result of child welfare policy (i.e. stepping down to less restrictive settings). Older youth in foster care also tend to have higher rates of psychiatric disorders and are two to three times more likely than their same-age peers to be prescribed psychotropic medications (Leslie et al., 2011; Raghavan, Lama, Kohl, & Hamilton 2010).

Engagement. Researchers have previously called for the assessment of strengths and collaboration between child welfare systems and mental health systems; however the focus of previous research has typically been on disparities related to younger children and those remaining in the home (Hurlbert et al., 2004). Within the foster care system, youth engaged in mental health services typically have treatment teams composed of caseworkers, caregivers, mental health professionals, and legal professionals (Longhofer, Floersch, & Okpych, 2011; Naylor et al., 2007). McMillen et al. (2007) surveyed professionals involved in child welfare and mental health systems regarding the quality of services provided to youth, finding that psychiatrists and mental health professionals are typically making the majority of the decisions with little perceived input from other members of the treatment team.

Scannapieco, Connell-Carrick, and Painter (2007) suggest that youth want to be more involved in making decisions about their care and future; foster youth and foster parents consistently reported a lack of involvement in decision-making and lack of individualized plans. Although the study of McMillen, Fedoravicius, Rowe, Zima, and Ware (2007) did not encompass involvement of youth in treatment teams, it provided that caseworkers felt a lack of involvement in decision-making based on reasons of either lack of psychotropic medication knowledge or unwillingness to challenge the prescribing doctor. If legal guardians of foster children perceive little power in medication decisions,

youth in foster care likely have even less perceived control or input on treatment teams.

Decision-making is likely impacted by knowledge and attitudes toward help-seeking. Munson, Narendorf, and McMillen (2011) provided vignettes to older youth in foster care to elicit their knowledge about mental health services. Most youth seemed able to identify a need for help in situations, but were not able to provide much rationale as to why help was needed or how to acquire help. Few youth were able to identify specific service providers available from whom to seek help (Munson et al., 2011). Youth with a history of depression tended to have more knowledge and positive attitudes toward help seeking. The study relied on self-report and situational vignettes, and could be limited by social desirability or underestimation; however it provides considerable support for educating youth how to recognize symptoms of mental disorders as well as where and how to access support.

Intergenerational Transmission of Child Maltreatment

Exposure to trauma and its impact on the mental health of youth in foster care not only impacts the well-being of these youth but also has the potential to affect the next generation as these young adults begin families of their own. The effect of abuse and neglect on behavioral and emotional development is important to consider in regards to adult outcomes and the potential for maltreatment in the next generation. There is general consensus that there is not a single mechanism or pathway in which maltreatment occurs, nor a single outcome in which it is expressed (Belsky, 1993; Cicchetti & Toth, 2005). Although the pathway of maltreatment is more of a complex interaction between risk, protective, and mediating factors, it is plausible to consider that a child's behavioral and emotional development would affect their psychological well-being as a young adult.

The long-term behavioral and psychological consequences of childhood maltreatment have been studied over generations, with the general conjecture that individuals who have experienced childhood abuse or neglect are at increased risk of maltreating their own children (Dixon et al., 2005).

Youth involved in the child welfare system typically have a long and complex trauma history, which may not always be fully recognized or addressed. Left inadequately unaddressed, this trauma can impact adult psychological functioning and relationships. Evidence suggests that adult psychological distress contributes specifically to poor parenting (Kotch et al., 1995) and is a risk factor for the intergenerational transmission of abuse and neglect (Dixon et al., 2005; Marshall et al., 2011). Parents with histories of childhood maltreatment, who experienced adult psychological distress as a possible consequence of trauma experienced early in life, may be at greater risk for perpetuating the cycle of child maltreatment. Kotch and colleagues (1995) interviewed 841 teenage mothers who had just given birth in a southeastern state, asking questions related to several ecological areas such as individual, family, neighborhood, cultural, and stress domains in an attempt to predict child maltreatment within the first year. The study determined five predisposing factors related to child abuse and neglect reports within the first year of the child's life, including low maternal education, teen mother separated from family before 14, other children in the home, maternal depression, and receipt of Medicaid (p values $< .05$). Parents struggling with psychological distress such as PTSD and depression may be at higher risk than other parents of abusing or neglecting their children, $F(2,99) = 11.07$, $p < .05$ (Pears & Capaldi, 2001). As a result, young adults with impaired psychological functioning may become parents who have trouble

providing developmentally appropriate and responsive care to their children.

Although psychological distress may negatively affect parenting, studies are increasingly finding that psychological distress does not fully account for the quality of parenting (Cicchetti & Toth, 2005). Using data gathered in a home visit program for newborns, Dixon et al. (2005) compared the parents who reported childhood history of abuse (n = 135) and those without such reports (n = 4216), to examine which factors could be related to the likelihood of intergenerational transmission of maltreatment. Adults with a history of child maltreatment were more likely to abuse or neglect their own children if they were also parenting at a young age, had history of mental disorder, or resided with a violent adult, OR = 2.96, 95% CI [1.74, 5.05], OR = 8.66, 95% CI [5.87, 12.79], OR = 5.03, 95% CI [2.30, 11.10], respectively; which together accounted for 53.4% of the total effect. These factors must be considered in context and the study cannot establish causality. Knowledge of these mediating factors is important to understanding the complexity of the intergenerational transmission of maltreatment. The study is also limited by self-report data and the families were only followed for 13 months after birth.

Clearly, there is no shortage of evidence that maltreatment can lead to psychopathology (e.g. Dixon et al., 2005; McLaughlin et al., 2012), which can impact parenting and maltreatment in the next generation. It is difficult to make overarching estimates about the proportion of parents with a history of childhood maltreatment that will go on to abuse or neglect their own children, due to the complexity of the mechanism and contextual factors that must be taken into account. Although not all maltreated children with mental health issues will perpetuate the cycle of abuse and neglect,

evidence suggests it's an important consideration and point for contemplation of current child welfare systems. Effective intervention while youth are still in the system is important, and providing support during the transition to adulthood is necessary as young adults are making independent decisions and possibly starting families. Exploring the perspectives of youth in transition may provide useful direction toward developing effective policies and interventions to prevent child maltreatment in future generations.

Youth Aging out of Foster Care

There is a growing body of research on youth who age out of the foster care system and transition to adulthood. These youth represent a particularly vulnerable population often characterized by their resiliency and aptitude for survival, yet also having poorer outcomes than their same age peers in many areas of adult functioning. A closer look at this population provides insight to some of the unique strengths and barriers they face as they transition to adulthood.

Transitions. Youth transitioning from care face a variety of obstacles as they leave a system of care that required their dependence to an abrupt expectation of independence in areas such as finance, housing, healthcare, and personal responsibility. In a review of international research, Stein (2006) characterizes outcomes for youth who leave care in categories of "moving on," "surviving," and becoming "victims," as a result of past experiences of maltreatment, experiences within the system, and support they receive after leaving the child welfare system. The first group of youth who successfully "moved on" had a more gradual transition including interdependent living after aging leaving the system, a sense of secure attachment in family and social relationships, and a sense of stability. "Survivors" are youth who experienced instability, moving several

times while in care as well as after leaving (Stein, 2006). They were more likely to be detached and feel self-reliant although had higher instances of agency assistance.

The group that struggles the most are what Stein (2006) refers to as "victims." They often had very traumatic family experiences and remain unable to overcome these difficulties while in care. Victims were more likely to have emotional and behavioral difficulties and to experience unemployment, homelessness, and mental health difficulties (Stein, 2006). Recognizing the different pathways youth enter and exit care is important when considering support and services to best meet their needs as they near the age of majority. Youth with more severe mental health needs may be enrolled in services but there may be a disconnect; youth who have moderate needs may be overlooked as they are seen as resilient and independent, already. Other researchers have found that many youth leaving care report not understanding they were able to stay in care and receive services after reaching the age of majority or felt like they were forced to leave the system for unplanned reasons such as failing grades in school, choosing school over work, or juvenile detention (Goodkind, Schelbe, & Shook, 2011; McMillen & Tucker, 1999).

Outcomes. Outcomes for youth who age out of care have been consistently studied in both cross-sectional and longitudinal research. The Midwest Evaluation of Adult Outcomes for Foster Youth is a comprehensive longitudinal study following 732 youth in three states from 17 to currently 26 years of age (Courtney et al., 2004; Courtney et al., 2005; Courtney et al. 2007; Courtney et al., 2011). Across all five waves of the study, youth aging out of the foster care system are faring worse than same age peers across a range of outcomes. At age 26, 20% of young adults still lacked a high school

diploma and only 8% had a postsecondary degree, as compared to 6% and 46% of the general population, respectively (Courtney et al., 2011). Only half as many former foster youth were employed at age 26 and 82% of young men had been arrested at least once since they aged out of care. Young adults in all waves were more likely to have experienced homelessness and issues with substance than their same age peers (Courtney et al., 2011).

Likely contributing to negative health and mental health outcomes, many youth also lose health insurance after aging out of care. Kruszka and colleagues (2012) highlight the barriers youth experience when they lose Medicaid insurance, such as not having the necessary documentation or knowledge of how to access services or not even being aware they were eligible for services. Under the Fostering Connections to Success and Increasing Adoptions Act passed in 2008, states had the opportunity claim federal reimbursement and extend foster care up to the age of 21, however only 30 states are participating as of 2013 (Pergamit, McDaniel, Chen, Howell, & Hawkins, 2012). With new policies in the Affordable Healthcare Act proposed to go into effect in 2014, health coverage benefits for all foster youth will be extended to age 26, which could be a substantial benefit for youth (Pergamit et al., 2012).

Social support. A key element to the period of interdependence is the support of significant adult relationships. Youth in foster care often report a disconnect with supportive adult relationships after they age out of care (Scannapieco et al., 2007), and only 34% of youth leaving care report a long-term significant relationship or mentor (Munson & McMillen, 2009). This shortage of supportive adult relationships translates to a lack of social capital to help the youth succeed in a variety of areas such as

employment and education. Coleman (1988) explains that social capital is a property of the social context, which can enhance an individual's value and enables them to achieve goals they otherwise could not have achieved. Social capital is formed as a result of relationships between parents and children, families and communities, and families and institution. As there is often a lack of permanency with biological or foster family members, youth aging out of care are lacking in the area of social capital.

Beyond providing connections and social support systems, an often overlooked area of social capital is the knowledge and/or access to appropriate services. Social networks serve as a form of an information channel, in which information that can facilitate action is shared (Coleman, 1988). Services or opportunities may be available, of which youth in foster care may not be aware of. Studies of older youth in foster care delineate that youth's knowledge related to service providers and justifications as to why help was needed was low (Munson et al., 2011). Processes of transferring from children's to adult insurance and mental health systems can also be difficult to navigate without prior experience, with more stringent requirements and lack of shared client planning (Davis & Sondheimer, 2005). Lack of experience or knowledge of how to navigate these services is a considerable barrier to youth transitioning to adulthood. Even if policies and supports are in place for youth nearing the age of majority, such help does little good if youth are not aware of their existence or how to access them, if they even believe they still need them.

In a longitudinal study, McCoy, McMillen, and Spitznagel (2008) found that less than half (45.8%) of youth initiated leaving care of their own accord, with other youth discharged with little notice or explanation. When asked, youth who initiated leaving

care reported frustration with the system, a desire for independence, or failure of the system to provide appropriate services as reasons for leaving the system (McCoy et al., 2008). It is unclear what frustrations or specific service needs the youth in this study had. Another study indicates that youth aging out express challenges in communication and lack of accurate knowledge about supports and services available (Scannapieco et al., 2007). Even if services are available they are of little use, if youth are not aware of how to maintain access to services or how to re-engage if necessary.

Mental Health Transition to Adulthood

The issues foster youth experience as they age out of the child welfare system are interwoven with issues of mental health. It is especially striking that McMillen and Raghavan (2009) report that mental health service utilization declined by 60% for foster youth within a month of leaving care, for both reasons of systemic barriers as well as related to dissatisfaction with medications. Youth who reported stopping medications were asked their primary reason for discontinuing, with 31% reporting not wanting to be on medications or did not feel they were needed, 25% did not feel that it was working, 17% discontinued due to experiencing adverse effects, and 12% reported barriers such as cost, running out, or not knowing where to get it filled (McMillen & Raghavan, 2009). Other studies have also identified cost and lack of insurance as barriers to receiving mental health care after aging out, although most often young adults say they discontinue on their own accord (Courtney et al., 2005; Kruszka et al., 2012). It has also been suggested that pediatric and adult mental health systems lack shared client planning, and the requirements in adult systems are typically more stringent, which increases the difficulty in transition between systems (Christian & Schwartz, 2011; Davis &

Sondheimer, 2005). Although there are obvious systemic barriers to accessing and maintaining mental health services, it is unclear from these studies how youth perceive these barriers and whether they leave services due to these barriers. Satisfaction with services is an issue consistently measured, however little research has expanded on this dissatisfaction and if they prefer not to continue services due to a sense that services are not improving their well-being.

Pecora and colleagues (2006) have also conducted large-scale studies on the outcomes of youth formerly in foster care. Taking a retrospective look at many areas, Pecora et al. (2006) found in the Northwest U.S. that youth completed high school at similar rates to same age peers (84.8%), although more often via GED. Former foster care youth again experienced high levels of unemployment (80.1%), homelessness (22.2%), and often had incomes at or below the poverty level (33.2%) (Pecora et al., 2006). Considering the mounting challenges and poor outcomes with fundamental expectations of adulthood such as housing and employment, it also makes sense that foster youth continue to have problems with mental health after aging out. The Northwest study (Pecora et al., 2003) also provided insight into mental health outcomes for former foster youth. Interviews with 479 former foster care youth found that youth in the study exceeded the general population in all nine mental health disorders assessed by the Composite International Diagnostic Interview (CIDI), with PTSD (30.0%) and major depression rates (41.1%) being much higher than the general population (7.6%, 21%, respectively). Foster care alumni ages 20 to 33 retrospectively reported information, which was compared to general population studies which can be problematic due to varying diagnostic methods and age ranges and diversity of the populations involved.

Especially concerning are the high reports of PTSD and depression, which are likely a result of unaddressed early maltreatment and trauma.

Just over a third (34.7%) of former foster youth in the Midwest study reported symptoms of social phobias, a quarter (23.8%) experienced symptoms of depression, and more than half (58.6%) reported symptoms of PTSD in the past year (Courtney et al., 2011). For having been out of the system for 10 years, these numbers are concerning about the appropriate services available to address their needs while in the system as well as currently. Courtney and colleagues (2011) also examined mental health service utilization in the past year, demonstrating 12% received psychological counseling, 15% received medication, and 5% were hospitalized. Also of interest were reasons young adults chose not to seek care which included not knowing where to go (18%), financial burden (36%), not having transportation (14%), inconvenient hours (23%), or no insurance (23%). Further explanation or contextual information was not provided regarding mental health services or reasons for not seeking care.

Knowledge and attitudes. Although it is recognized that there is not an objective knowledge of mental health, determining what youth understand about services may help explain their experiences navigating mental health systems and decision-making process. Jorm (2000) describes 'mental health literacy' as the recognition of one's psychological distress, appropriate help-seeking, and knowledge of how to seek mental health information. In a study of 268 older adolescents in foster care, Munson et al. (2011) concluded that the youth tend to have moderate mental health knowledge and their knowledge related to service providers or justification as to why help was needed was low. Researchers coded open-ended responses to vignettes on a scale of (0) no help

was needed, (1) I'd help or don't know, (2) enlist a responsible adult, (3) enlist a professional helper, (4) knows the name of an agency or service, or (5) knows name of agency/service and has justification for service (Munson et al., 2011). Overall, Munson and colleagues (2011) reported that older youth with histories of PTSD and depression had higher levels of knowledge than those who had never met diagnostic criteria ($\beta = .13$, $p < .05$ and $\beta = .08$, $p < .05$, respectively). Youth with a history of inpatient hospitalization were determined to have more knowledge than those without such history ($\beta = .04$, $p < .05$). This study relied on vignettes and self-report data which may be biased towards social desirability and recall; it also seemed to be based on somewhat arbitrary cutoffs for knowledge of mental health services even though inter-rater reliability was reported as 90%. The study also demonstrates an embedded bias toward seeking professional help, which may not be the solution deemed best by the individual.

A sense of independence, such as that gained by aging out of the system, can be simultaneously empowering and anxiety-provoking. Feelings of psychological empowerment are related to increased participation in services as well as self-efficacy in mental health (Ungar & Teram, 2000). Having more choice in participation and specific services provides youth a voice in decision-making and youth who have knowledge and access to services are more likely to feel capable of utilizing services. Feelings of empowerment can also be related to social support, for which there is considerable research regarding the need for social support as foster youth transition to adulthood (Avery, 2010; Collins et al., 2010). Lack of satisfaction with the system and services is a recurrent theme for youth leaving foster care, but little specificity is provided by most studies. Attitudes toward help-seeking from adults may also play a role in this

satisfaction with needs being met and service utilization. Although research supports that adolescents prefer to handle emotional and behavioral issues on their own, it also suggests their belief in the professional's ability to provide practical support increases the likelihood of seeking help (Del Mauro & Williams, 2012; Sheffield, Foirenza, & Sofronoff, 2004). The perception of need, knowledge of services, and practical support lead to service utilization, but satisfaction and positive attitudes toward services increases the likelihood of continued use.

Systemic factors. Kessler et al. (2008) examined difference in adult outcomes of private versus public foster care for adolescents, interviewing former foster care youth about their experiences in foster care as well as current adult mental health outcomes. Adults who were in privatized foster care had lower occurrences of depression (11.3% vs. 24.3%), substance use (5.1% vs. 11.1%), and/or anxiety disorders (28.8% vs. 40.0%).

Privatized foster care also tended to provide more stable placements and caseworkers had higher education, lower caseloads, and access to a wider range of services to provide to youth in care (Kessler et al., 2008). Although the study again relied on retrospective analysis and self-report, it shows the importance of systemic factors and availability of services related to more positive mental health outcomes. The more efforts that are invested while youth are in care, likely lead to more positive outcomes after they age out.

Issues with policy development and service implementation are well-documented in literature related to mental health services and youth aging out of care. Application of the developmental ecological perspective allows a more in-depth exploration of individual, social, and institutional barriers that face this population. For example,

Kruszka and colleagues (2012) examined experiences of uninsured former foster youth, interviewing nine young adults who did not have health insurance after aging out of the system. Some were unaware of eligibility for Medicaid or faced significant barriers to re-enrolling such as leaving care without guidance or documentation needed to apply/reapply; eight out of nine participants were denied coverage though they were eligible and most were not enrolled before leaving care (Kruszka et al., 2012). These systemic barriers in both policy and practice dramatically affect outcomes for youth leaving foster care. Considering how these effects interact within systems as well as the individual is important to understanding how each piece of the puzzle impacts outcomes and decisions made to utilize health services. If a youth does not know how to enroll or were not enrolled before they turned 18, they may be denied coverage if they even try. Even more concerning is that if a youth was enrolled in care and understands how to renew, he or she may still be denied coverage for which they are eligible.

Contextual considerations. If foster youth are engaged in services and available supports they may be able to take advantage of a period of interdependence, which arguably contributes to more positive outcomes than simply transitioning to independent living (Avery, 2010). Most state child welfare systems have policies extending financial and residential support until age 21, yet 67.5% of youth do not intend to remain part of the system after turning 18 (McCoy et al., 2008). If policies and programs exist to support youth during this transition to adulthood, the question remains why more youth are not utilizing such services. Gilmer, Ojeda, Fawley-King, Larson, & Garcia (2012) conducted a study to examine mental health service utilization among young adults (18-24) who were involved in an outpatient program designed for their transitional age. The

intervention followed an adult psychiatric rehabilitation model tailored for young adults and administered by staff with experience providing services to this population. Findings supported the hypothesis that youth receiving developmentally tailored support used services on average 12 times as often when compared to same age peers in regular adult programs (Gilmer et al., 2012). The program focused therapy on topics such as relationships, family supports, and housing which all likely contribute to strengthening supports and independence, but the "developmentally appropriate" factor of the program was simply the collaboration with child welfare systems. More information is also needed regarding the reasons for discontinuing services, in an attempt to understand how to develop effective policies and programs to adequately support this population.

The longitudinal Midwest study (Courtney et al., 2011) provides insight into a variety of considerations such as employment, relationships, education, and mental health to name a few. The study indicates that 20% of former foster care youth were engaged in mental health services at the age of 26, as opposed to 11% at ages 21 and 23, 14% at age 19, and 38% at age 17 and still in care (Courtney et al., 2004; 2007; 2009; 2011). Youth meeting criteria for mental health disorders was around a third in all evaluations. This is useful to consider that as expected, youth in care are engaged in mental health services at higher rates which drop off considerably after aging out; however, it is interesting to note that the rate of service utilization increased again after 10 years out of care, suggesting a trend of returning to services much after leaving care. The study highlights that there are many contextual factors to consider in the phenomena of youth aging out, but does not explore how youth came about these decisions. Considering mental health and service utilization as a piece of overall outcomes for youth aging out of foster care is important

and recognizing that each of these systems and environments interact with the individual is relevant, however, the study takes such a broad examination of outcomes that there is little specificity in experience. Delving more in-depth in one area such as mental health services allows a focus that would then likely have impacts on other areas of functioning as measured in the Midwest study.

In another related study, Fowler and colleagues (2011) examined the role of contextual support in mental health of youth aging out, suggesting that the absence of social and environmental supports is connected to psychological distress. Consistent with developmental ecology is the context examined and how it may change over time to affect an individual. Considering housing, education, and employment as developmental outcomes provided that youth who experienced stable housing and varying connections to education and employment were more likely to experience mental health than those with instability in such areas (Fowler et al., 2011). Applying a perspective that encompasses how various contextual factors impact development is very useful in policy development and service implementation because it helps identify multiple areas and systems that need improved, to promote stability and successful outcomes and mental health.

Developmental Ecological Theory

Considering the variety of individual and environmental factors, which contribute to the experiences of mental health services for youth aging out of foster care, it may be useful to view the problem though a developmental ecological perspective. Ecological systems theory provides a framework for understanding human development and decision-making as a result of individual actions, environmental occurrences, and the

interactions between the two (Bronfenbrenner, 1979). Considering the meaning people assign to their experiences in the context of the environment has a significant impact on how events influence their decisions and well-being. The very premise of the research area of youth aging out of the child welfare system and concurrently interacting with the mental health system demands examination of the individual's influences, both directly and indirectly impacting their decisions and experiences. Roles change and individuals and systems accommodate.

Levels of individual structure and function were included in Bronfenbrenner's bioecological model to account for the developing person as part of the system. Focus also shifted toward differentiating between the environment and process. According to the model, proximal processes account for the interactions between the individual and environment in the microsystem (Bronfenbrenner & Morris, 2007). These processes vary as a function of the person's biological, cognitive, and behavioral characteristics, the context of their development, and the involvement of time across the lifespan. These interrelated properties of process are considered for not only the individual, but also as characteristics of people with whom the individual interacts with consistently over time (Bronfenbrenner & Morris, 2007).

Focusing on the setting and change over time fits well with the population of youth in foster care and aging out to independent living. Systems are such a dynamic and often changing part of their lives that the interaction and processes between them would impact their development. Youth in foster care and youth with mental health needs are a heterogeneous group in which experiences and expectations change over time and based on interactions. Including the individual's biological, psychological, and social

characteristics may make assessment and intervention more complicated and maybe never fully understood, but it allows for a more realistic picture of their development and behavior which would likely lead to more appropriate interventions and programs. This perspective accounts for the relationships and influences that affect individual life courses based on daily interactions. Understanding the fit between relationships and systems is helpful in examining perspectives of maltreated youth engaging in multiple systems on a daily basis (Belsky, 1993). Examining the perspectives of foster care youth who are aging out provides insight from the stakeholders themselves as to how they perceive their environment and experiences in the decision-making process and what factors have influenced these decisions over time.

Maltreated youth have increased occurrences of psychopathology and poor outcomes compared to their same age peers (e.g. Courtney et al., 2011; Pecora et al., 2009). Considering how trauma has affected these youth is important as it contributes context, as does current access and utilization of services. Understanding how a youth's social ecology contributes to their own mental health as well as outcomes in future generations by affecting their likelihood of maltreating their own children. Anderson and Mohr (2003) apply the developmental ecological perspective to children with mental health needs, providing that systems of care consist of interacting systems and interventions. Considering that youth in foster care interact with a variety of systems, as well as varying levels of family and community, research and practice with this population should be approached from a developmental ecological perspective. Assessment and interventions, which reflect context in relation to individual, family, and community characteristics, provides a more comprehensive and proactive response to

children's mental health. Anderson and Mohr (2003) call for assessment and practice to reflect context and multidimensional needs; doing so will simultaneously address child and environmental characteristics, which allow for more holistic service system delivery.

Contributing theories. Recognizing the importance of multiple interacting systems includes recognizing the value of multiple developmental theories that may impact the process of decision-making for youth aging out of foster care. For example, understanding the expectations of normative adolescent development, the evolving developmental stage of emerging adulthood, and theories of problem-solving may serve as important foundational knowledge related to the decision-making of youth aging out of foster care. In addition, consideration to trauma and the social work strengths perspective are also important to acknowledge when focusing on issues encountered by this particular population.

Understanding adolescent development is important when considering development and behavior of youth aging out of foster care. Youth in foster care have likely experienced early life stress and trauma in addition to impending transitions to adulthood. Separation from families and instability that accompanies multiple transitions likely compounds this trauma. In addition to hormonal and physiological changes to appearance, brain structures continue to develop and mature through adolescence (e.g. Blakemore & Choudry, 2006). Specific brain structures such as the amygdala and frontal lobes are related to emotions, insight, and problem solving, which are important to consider since the expectation is for more mature and independent decisions as youth near adulthood.

Socially, adolescents are navigating changing social roles and responsibilities as

well as testing their own sense of autonomy and authority. Research has focused on family relationships during adolescence, suggesting an emotional distancing and difficulties adjusting to the adolescent's increasing desire for autonomy are common (Steinberg & Morris, 2001). Conflict and dysfunction in parent-adolescent relationships can lead to problems with psychosocial well-being. Difficulties with early parental attachment may lead to difficulty with relationships in the future. Keller, Cusick, and Courtney (2007) conclude that adolescents who felt distressed and disconnected were most likely to experience psychosocial difficulties. Because youth in foster care are likely to have entered care due to family dysfunction, it makes sense that primary social relationships have an impact on their own development and self-esteem.

More recently, literature has depicted a developmental period between adolescence and adulthood, in which young adults are exploring and negotiating their independence. This developmental "coming of age" in modern, westernized cultures has been conceptualized as the period of emerging adulthood, with identified experiences and milestones which may offer insight into the transition to adulthood for youth aging out of foster care. Arnett's (2007) underlying assumption for distinguishing this stage of emerging adulthood was the feeling of being "in-between" adolescence and adulthood that many young adults expressed: graduating from high school, past puberty, and no longer living with parents, but not yet fully independent and reaching criteria they considered "adult" such as finishing education, achieving financial independence, getting married, and generally accepting responsibility for themselves. Most young adults surveyed agreed that these criteria were gradual transitions rather than abrupt, definite transitions (Arnett, 2007).

Although emerging adulthood has gained considerable attention in recent years, it may not accurately represent the circumstances of young adults of particularly disadvantaged populations. Specifically, youth aging out of the foster care system often lack the social and systemic support needed to extend this developmental stage of identity exploration, and are expected to transition from a system of dependence to a world of independence in a rather sudden manner. They are expected to attain independent, adult-roles upon reaching the age of 18; yet studies have continued to show poor outcomes such as problems with mental illness, substance abuse, homelessness, unemployment, and decreased graduation rates (e.g. Courtney et al., 2011; Scannapieco et al., 2007). By having such a short period of time of identity exploration, foster youth are taking on adult roles often before they acquire the skills, experiences, resources and other assets that increase the likelihood of success.

Theories of problem-solving depict the behavioral process by which an individual's response to a specific situation is impacted by knowledge of resources and potential solutions and consequences (D'Zurilla & Goldfried, 1971). How youth aging out choose to manage their mental health depends on the resources available and other environmental circumstances. Professional and social support, as well as tangible resources such as transportation and finances, impact problem-solving for this population. Even if youth are motivated to seek services, lack of resources or opportunity may be a barrier. For example, youth often have access to mental health services while in care, but their knowledge and access after aging out is questionable.

Problem-solving is also impacted by attitudes towards seeking professional help, which are influenced by previous experiences, societal expectations, and perceived

behavioral control (Greenley & Mechanic, 1976). Youth in foster care are essentially relegated to a system of dependence, where they do not often have much control over decisions that are made; as they reach the age of majority they are often expected to immediately transition to independence, or a situation in which they have considerable perceived control. This transition obviously varies by individual and sources of support available, but the unique idea of perceived control related to being in a system of care is worth noting as an important consideration to the problem-solving process.

The need to understand contributions of adolescent development, emerging adulthood, and problem-solving theories is further complicated for foster youth who often have long and complex histories of trauma. Trauma-informed care acknowledges the traumatic experience and its impact on behavior and decision-making (Hopper, Bassuk, & Olivet, 2010). Traumatic stress impacts daily functioning and has the potential to significantly disrupt development and result in profound long-term consequences. Although professionals recognize childhood adversities and trauma experienced by youth in foster care, providing trauma-informed care goes a step further to understand how that traumatic stress impacts the individual and their physical and emotional safety (Hopper et al., 2010). For example, foster youth often present with behavioral or emotional problems when they come into care; taking a trauma-informed perspective would acknowledge the role of trauma in the individual's display of mental health symptoms, impacting assessment and treatment.

Finally, the strengths-based practice is a social work practice theory which emphasizes an individual's self-determination and abilities. The strengths perspective (Saleebey, 1996) recognizes intrinsic qualities such as motivation, skills, and perspective

of situational demands. Recognizing the vulnerabilities and issues which have resulted in child welfare and mental health system involvement is important to understand history and context for youth aging out of care, however a more comprehensive understanding can be obtained by attention to skills and relationships the young adults have in addition to qualities such as initiative, resilience, and self-efficacy. This perspective tends to provide more balance pathology and vulnerabilities, by also focusing on existing strengths and self-determination (Saleebey, 1996). Mental health and child welfare services are often initially directed by crisis and personal safety; however ongoing services and decisions whether to continue to engage in services are more dependent on assessment of both vulnerabilities and strengths.

Conclusions. This study focused on not only the interaction of child welfare and mental health systems but also the match of these interactions between the individual's biopsychological development and these systems. The developmental ecological perspective is useful for addressing heterogeneous, complex social problems. It also fits this population well because adolescence and emerging adulthood are marked as life stages with considerable development and contextual variation. Consideration of the developmental stages and tasks of both adolescence and emerging adulthood may provide insight into contextual factors as well as influences in decision-making and help-seeking behaviors.

Although the developmental ecological theory appears to account for the variety of biological, psychological, and environmental factors influencing the population of interest, it is also important to use caution in broad application of the theory. Although developmental ecology intends to understand the match and interaction of systems

affecting the individual, it lacks in the ability to predict mechanisms or direct causes. The theory proposes that individual development is impacted by biology, but also people and other systems in their environment, and there is no single cause or predictable outcome as a result of varying interactions (Belsky, 1998). The individual's match to the systems in their environment may vary based on experience and development, which is vice versa affecting the systems. Clearly there is value in examining multiple factors related to experiences with mental health services for youth aging out of care, but instead of determining direct causes, we can only determine what factors influence decisions.

Youth leaving the foster care system have poor aggregate outcomes (e.g. Courtney et al., 2011). Studies have attempted to discern reasons for outcomes, but there remains a disconnect between current policies and programs and effectively meeting the needs of youth aging out of care, as demonstrated by the small numbers of youth remaining in care until age 21 and far fewer who maintain mental health services after turning 18. There is a need to understand the perspectives of foster youth, regarding their ability to meet their mental health needs as they transition to adulthood including satisfaction with services. Gaining insight about these experiences offers a unique position to provide voice to this group and provide policy and practice implications to improve outcomes for foster youth transitioning to adulthood. Creating systems that can effectively support youth transitioning to adulthood may allow youth the extended stage of emerging adulthood, likely improving successful outcomes. Exploring the perspectives of the youth in transition may provide useful direction toward developing effective policies and interventions to accomplish this goal.

Chapter 3

METHODS

The current study aimed to address a gap in the literature regarding the barriers and strategies used to meet the mental health needs of youth aging out of the foster care system. The research question involved an in-depth exploration of the mental health needs and service utilization of foster youth, as they transition to adulthood and are making independent decisions about their own mental health. Understanding what challenges as well as supports youth aging out of foster care encounter related to their mental health, provide insight into this complex phenomena and offer direct practice and policy implications.

Research design

Considering the need to understand how former foster youth experience challenges and supports necessitates an in-depth exploration of experiences; determining which experiences are most important to a larger population requires a measurement of the most intense and frequently encountered experiences. The behavior analytic model (Goldfried & D'Zurilla, 1969) provides a sequential exploratory design with which to examine the challenges and supports youth aging out encounter in meeting their mental health needs. A sequential exploratory design allows qualitative findings to inform the development of an instrument in a two phase process to better understand how phenomena are experienced by a particular population (Creswell & Plano Clark, 2011). This study utilized the qualitative approach to identify situations and strategies which impact decision-making for youth aging out, and then used quantitative methods to determine the degree to which these situations lead to mental health competence and

successful outcomes, also from the youths' perspective.

Although more commonly used in clinical psychology, the behavior analytic model also aligns well with the field of social work due to its ecological approach to considering behavior. According to Goldfried and D'Zurilla (1969), the effective response of an individual to life situations is influenced by the individual's environment as well as potential consequences, such as alleviation or exacerbation of symptoms or stress. It is not assumed that all youth aging out of foster care experience mental disorders, but it has been well-documented that foster youth disproportionately struggle with mental health issues (e.g. dos Reis et al., 2001; McMillen et al., 2005) and youth aging out of foster care face higher rates of social and emotional problems than transitioning youth in the general population (e.g. Courtney & Dworsky, 2006; Pecora et al., 2006). Understanding what these youth view as problematic situations and environmental influences and strategies to respond to these situations provides a framework for designing interventions to teach skills to effectively navigate difficult situations. Taking an ecological perspective, these findings might also uncover the need to address systemic issues related to mental health policy and practice for youth aging out of care.

The behavior analytic model has been used with a number of populations, including college freshmen (Goldfried & D'Zurilla, 1969), severely emotionally disturbed adolescents (MacNeil, & LeCroy, 1997), adolescents with chronic illness (DiGirolamo, Quittner, Ackerman, & Stevens, 1997), and urban middle-school adolescents (Farrell et al., 2006; Farrell et al., 2008). Each study applied steps of the model to understand situations impacting an adolescent population, to inform related

policies and programs. In each variation of the model, the emphasis remained with both the individuals and the situations they encountered, to assess the relationship between their behavior and the environment to which they were reacting (Goldfried & D'Zurilla, 1969).

This ecological conceptualization assesses problematic mental health situations youth aging out are likely to face in their communities. It also provides information about what competencies and skills they may lack. Although the behavior analytic model addresses problematic situations and deficiencies, a social work practice perspective requires acknowledging strengths and protective factors (Saleebey, 1996), which also contribute to the individual's competency and perspective of situational demands. Focusing solely on reducing problems limits opportunities to acknowledge the complete experience of the transition; including not only possible deficiencies, but also recognizing strengths and personal attributes such as initiative and self-efficacy, which contribute to successful transitions and outcomes (Lindsey, Kurtz, Jarvis, Williams, & Nackerud, 2000). By identifying both challenges and strengths, we can better determine what supports exist both from the individual as well as in the community to help youth transitioning to adulthood.

The five steps of Goldfried and D'Zurilla's (1969) behavior analytic model include: (1) situational analysis, (2) response enumeration, (3) response evaluation, (4) instrument development, and (5) instrument evaluation, which collectively provide a criterion analysis and establish an inventory for assessing social competence which then inform programs and policies to benefit the population. The current research focused on Goldfried and D'Zurilla's (1969) first step of situational analysis, to comprehensively

examine the situations in the environment that youth aging out must navigate to meet their mental health needs, as well as the frequency and importance of such situations. The project was completed in two phases to investigate problematic and successful situations of mental health services for youth who have aged out of foster care, each with its own sampling, data collection, and analysis considerations which will be discussed in turn. As depicted in Figure 1, the first phase aimed to assess environmental demands and created an inventory of responses. The second phase focused on evaluating social competence through the response evaluation and instrument development.

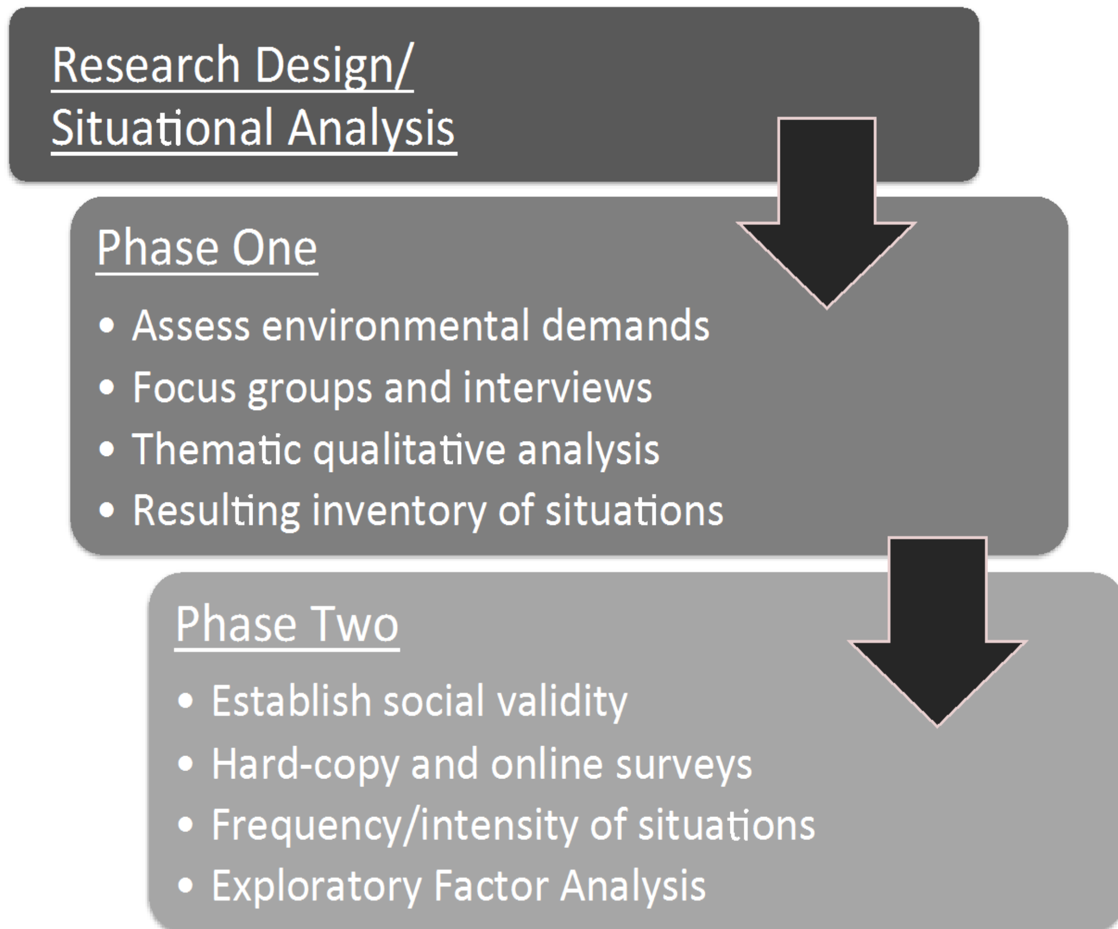

Figure 1. Situational analysis research design for assessing mental health services for former foster youth.

Phase One

Sample. To meet inclusion criteria for the study, participants must have been (a) living in an out-of-home placement (foster care) supervised by the public child welfare agency for at least a year prior to turning 18, (b) involved in mental health services prior to aging out, and (c) between the ages of 18 and 22 at the time of recruitment. Considering the average length of stay in foster care for youth aging out of the system is just over 3 years in Arizona but only 11 months nationally (AZDES, 2012; U.S. Department of Health and Human Services, 2013), it seemed appropriate to require at

least one year of placement with the system. Young adults are also allowed to remain in foster care in the state of Arizona until the age of 21 and are likely still college age at age 22, which constituted the upper end of the age range for inclusion criteria. With the recent Affordable Healthcare Act implementation, former foster care youth will be eligible for health insurance until the age of 26; however uncertainty remains regarding the ability to notify those within the gap of coverage at initial implementation (ages 21-26), so the age of inclusion was not extended for the current study (AZDES, 2012).

According to the Arizona Department of Economic Security (AZDES, 2011; 2012; 2013), there will be approximately 3100 youth between the ages of 18 and 22 with a history of foster care at the time of the study. Data collected by the state independent living coordinator for the National Youth in Transition Database (NYTD), indicate only 971 youth were still in contact with or reachable by state employees in 2012 (National Youth in Transition Database, 2013). Consistent with previous research, many young adults who no longer remained in contact with the child welfare system were located by their involvement in other systems such as criminal justice or through receiving other government benefits (Courtney et al., 2011). Youth who are incarcerated were not eligible for participation in this study. It was estimated that a realistic sampling frame for youth who have aged out of the foster care system in Arizona between the ages of 18 and 22 at the time of the study, who were also involved in mental health services prior to turning 18, was approximately 475.

With the assistance of the state independent living coordinator, agencies and community events were identified from which to draw participants for both phases of the study. Youth aging out can remain in foster placements, however previous research has

shown that by age 19, more than a third of youth who aged out changed living arrangements at least twice and 14% reported experiencing homelessness at least once (Courtney & Dworsky, 2006). For this reason, multiple agencies were identified to increase the diversity of the convenience sample to include both youth still in care and those living in other placements. Participating agencies included the DCYF Youth Advisory Council, Children's Action Alliance Youth Initiative, Magellan My Life, Homebase Youth Services, Sunshine Group Homes, Tumbleweed, One-in-Ten, and Arizona Children's Association.

A demographic survey was administered to former foster youth who met inclusion criteria, consisting of 13 questions to confirm eligibility and gather basic information such as gender, race/ethnicity, living situation, education, and income (see Appendix A). Participants were also asked if they would be interested in participating in a follow-up focus group and to provide contact information if they so chose. The initial demographic surveys were used to draw a sample for the first phase of data collection, based on those indicating interest and diversity in demographic information. Quota sampling was initially chosen to stratify the available sample from the demographic survey, allowing for a reasonable representation of the population to be obtained for the focus groups (Rubin & Babbie, 2010). However, it became apparent early in planning for the focus groups that this was an often-difficult population to engage due to a variety of circumstances including lack of consistent transportation, child care, work schedule, and time-management. Therefore, availability sampling was used such that youth who were available at the time of the focus group were included.

The behavior analytic model also involves gathering perspectives from additional people familiar with the problems and supports encountered by this population, to collect a more comprehensive sample of situations the population may encounter (Goldfried & D'Zurilla, 1969). Although the primary goal of the research was to raise up the voices of former foster youth as primary stakeholders, taking an ecological approach implied seeking additional perspectives to more richly understand the phenomena. As a result, this project also purposively sampled eight professionals with expertise of youth aging out with mental health services, including two Department of Child Safety independent living coordinators, a child welfare mental health specialist, a transition-age mentor with the regional behavioral health authority, two transition-age facilitators at behavioral health agencies, and two foster parents and group home managers of youth who have transitioned from care. For each sample and phase of data collection, letters of informed consent were reviewed with participants prior to their participation. These forms can be found in Appendices B and C.

Data collection. The goal of the first phase was to identify the mental health service problem situations and strengths most often encountered by youth aging out of foster care. To accomplish this, focus groups were conducted with the sample of youth who have aged out of foster care. Previous research has suggested that youth prefer group modalities, as it allows participant sharing and direction (Munson & Lox, 2013). Each group consisted of eight guiding questions and ranged from 70-120 minutes, to identify and describe situations deemed problematic or helpful to this population. The young adults were asked to individually make a list of difficult or challenging situations they have encountered related to mental health services and aging out of foster care, as

well as a list of supportive situations. They then shared and discussed the situations, and continued to identify challenging and helpful situations as a group. Prompting questions were used related to how the youth define mental health services, what their experience have been (e.g. if it was helpful or not and in what ways), if services have changed since aging out, if they felt their mental health needs were currently being met, and people that were helpful or to whom they could turn to for advice after turning 18 (Focus group questions are presented in Appendix D). Previous research has suggested three to five focus groups are needed to reach theoretical saturation (Morgan, 1998). The fifth and sixth focus groups in this project corroborated data from the previous groups without presenting additional themes, suggesting saturation was achieved. Focus groups were held at agencies as well as in the community and the young adults received a $25 giftcard for their participation.

Consistent with previous studies (e.g. DiGirolamo et al., 1997; Farrell et al., 2007) professionals and community members who work closely with youth aging out were also interviewed to obtain a multidimensional perspective of supports and challenges encountered by youth transitioning to adulthood and choosing whether to access mental health services. The eight interviews with professionals in the community consisted of the same prompts and opportunities to describe problematic and supportive situations as the focus groups, but from the perspective of the professionals working with this population (see Appendix E). Due to the desire for diversity in professionals/community members familiar with the population, it was most pragmatic to interview these professionals individually, rather than attempting to coordinate them in a focus group.

Professionals and community members also received a $25 gift card for their participation.

Analysis. The purpose of the qualitative phase of this project was to analyze the content of problematic and supportive situations into domains or themes, to inform an inventory for further evaluating the importance and frequency of these experiences. All focus groups and interviews were audio-recorded and the primary research also took notes and partially transcribed the recordings. As the primary purpose of this phase was to identify situations that would be refined and not quoted verbatim in the survey, the decision was made to review the recordings and extract themes and specific situations. Situations that were mentioned by at least two participants and/or where also mentioned in relevant literature were included in the pool of situations from which to create the inventory.

Situations were cleaned to provide specificity but also general enough to elicit responses from a variety of individuals. Items included enough detail/information about what may have precipitated the situation, but care was also given to the length of situations impacting overall length of the survey. Situations in the original and other research utilizing the behavior analytic model were often three to four sentences or even a couple paragraphs in length (DiGirolamo et al., 1997; Farrell et al., 2007; Goldfried & D'Zurilla, 1969). Considering overall survey length and limited timeframes available for participants to complete the surveys (e.g. between sessions at conferences or in passing), the decision was made to limit the situations to one or maybe two short sentences. Consensus decisions were made with committee members to establish the final pool of situations so that redundant items were eliminated and similar situations were combined

into one. Two adolescents and two social workers familiar with the population tested the resulting inventory for readability. It was then administrated to a group of 20 former foster youth, which necessitated further shortening of the overall survey. The final inventory included 54 challenging and 32 supportive situations.

The survey initially included additional scales of mental health functioning (CIDI-SF; Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998), attitudes towards help-seeking (ATSPPH-S; Fischer & Farina, 1995), service utilization (SACA; Stiffman et al., 2000), and overall social support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). Previous studies have identified that surveyed adolescents' perceptions of problematic and supportive situations varied related to self-reporting symptoms of depression, anxiety, and feelings of self-worth (DiGirolamo et al., 1997; Farrell et al., 2006). Although inclusion of these scales may have provided additional information for analysis, the determination to remove them was based on the overall length of the survey (10 pages versus six pages) and availability and developmental attention span of the young adults.

Phase Two

The relevance of the situations identified in phase one was assessed in the second phase of the project, through the inventory of mental health service experiences. The mental health service experience inventory was administered to a larger sample of youth who have aged out of foster care, as a method of assessing the social validity of the situations previously identified in phase one. Survey methods were chosen to allow for identification of larger population attributes from a smaller sample with quick data collection (Rubin & Babbie, 2010).

Sample. Non-probability convenience sampling was also used for the second phase of the study, from the same pool of agencies and community organizations previously identified for the first phase. A description of this sample is also provided in Chapter 4. Participants were allowed to fill out a hard-copy of the survey or an online version, to increase accessibility (Appendix F). Links to the online survey were shared with participants and community agencies, which could also be forwarded to other eligible participants. With the increased accessibility of an online version of the survey, the link was also forwarded to agencies and former foster youth in other states across the country.

Data collection. Surveys in Arizona were administered at community/agency events aimed at young adults who had aged out of foster care. After ensuring participants met eligibility criteria as designated in the first phase of the study, the researcher explained the general purpose of the study, obtained informed consent, and reminded the young adults they could discontinue participation at any time. Surveys generally took 15-30 minutes to complete, and youth received $10 cash for their participation. The online survey was administered through the online survey software Qualtrics, and participants received a $10 e-gift card for their participation. A link to the online survey was sent through agencies and community organizations serving former foster youth out in other states, providing a small number of responses for which participants also received a $10 e-gift card.

The survey itself consisted of 13 demographic, 54 challenging situation questions, and 32 supportive situation questions. The demographic questions were similar to the initial demographic survey from phase one, with some minor changes. For example, it

was apparent from the first phase that the income and disability questions were confusing for some participants, and did not appear to provide considerable information about the population, so they were removed from the second survey. In addition, rather than asking participants to recall the amount of time spent participating in mental health services, the decision was made to generalize the question to what services participants had used prior to turning 18 and after turning 18. This was decided because the focus of the second phase was more about decisions to use services rather than time spent in services. Specific descriptions of services were used from the Service Assessment for Children and Adolescents (SACA; Stiffman et al., 2000), for consistency with previous literature.

For the challenging and supportive situation questions, Likert-type scales were used to address the frequency with which the individual experienced the situation (from 0 “never” to 4 “1-2 times a day”), and the perceived difficulty or support they had managing the situation (from 0 “not at all” to 4 “couldn’t be worse/better”), similar to previous studies by Farrell and colleagues (2006; 2008). Goldfried and D’Zurilla’s (1969) original model depicted only the frequency of situations, whereas more recent models were modified to include the degree of difficulty of situations experienced (DiGirolamo et al., 1997; Farrell et al., 2006). MacNeil and LeCroy (1997) also included the importance of the situation as a third measure, but noted some confusion between “importance” and “difficulty” from many adolescents with diagnosed emotional disorders. To help limit systemic missing data, the situation questions were presented in reverse order. For example, approximately half of the surveys presented challenging situations and then supportive, and the others reversed the order by presenting all

supportive situations and then challenging. Further, the order of asking frequency and intensity for all situations was also reversed in approximately half of the surveys.

Analysis. Data were entered into SPSS version 21, cleaned, and inspected by the primary researcher. Participant cases that were more than 90% incomplete were deleted and not included in the analysis. Missing data analysis was conducted to determine if there were any patterns of missing data among participants and the variables. Missing data appeared to be at random and a complete-case strategy was used for analysis (Pigot, 2001; McKnight, McKnight, Sidani, & Figueredo, 2007). It is believed the missing data were attributable to accidental omission of responses on the survey, which could also be a result of the survey length and design, six pages with two columns of response for each situation.

Also during data inspection, it became clear that although all of the questions in the inventory referred to mental health services, there was not a designation made to delineate specific services, such as counseling, psychiatric medications, hospitalization, etc. All participants received all questions, regardless of which mental health services they had received, which presented two issues with the resulting data. First, participants may have rated situations with which they had not directly experienced. For example, some participants who did not report using psychiatric medications before or after turning 18, still responded with experiences on questions specific to medications, rather than marking 'never' as expected. All participants received all questions, regardless of which mental health services they had participated in, so marking 'never' as the lowest intensity was the only realistic option for those who did not participate in a particular service referenced.

Not delineating specific services also presents an issue with reported frequency of situations, as some services are available less frequently than others. For example, appointments and decisions regarding psychiatric medication management typically occur once a month or once every three months, per regional behavioral health authority standards, whereas other services and experiences such as transition services and counseling may occur more frequently. All of the situations were asked on the same Likert-type scale in this study, creating a limitation when comparing the most frequently encountered situations. These issues will be further explored in Chapter 5, but are noted for the purpose of transparency in analysis.

The relevance of problematic and supportive situations was analyzed by examining the mean frequency and difficulty ratings for each situation. Situations considered to have been experienced by a large number of participants and also deemed difficult to many participants were examined. Additionally, a series of exploratory factor analyses (EFAs) were conducted to identify the underlying factors of the inventory (Field, 2009), and to refine the pool of problematic and supportive situations. Identifying the number and nature of the underlying latent variables that influence relationships among measured variables provides the opportunity to develop an instrument that adequately measures and reflects their challenges and successes.

Specifically, an EFA was conducted with the 39 problematic situation items that did not include reference to psychiatric medication. Data were first examined for the assumption of normality, to which there was no univariate skewness values above plus or minus two or kurtosis values above plus or minus 7 (Curran, West, & Finch, 1996). The data also appeared normally distributed so maximum likelihood extraction was used with

varimax orthogonal rotation. Principle axis factoring extraction was considered and produced similar results to the maximum likelihood extraction, however the items loading highly on the same components did not theoretically make sense. Maximum likelihood was ultimately chosen because the results made more sense theoretically and offered additional indices to examine the fit of the model to help determine the most appropriate number and nature of factors (Preacher & MacCallum, 2003).

In terms of rotation, oblique is typically recommended as most factors are thought to be correlated in social science research (Field, 2009), however the decision was made to discriminate between factors as much as possible by using an orthogonal approach. To be thorough, additional rotations were tested as ways of fitting the same model to the data, but produced uninterruptable results when the pattern matrix was examined. For example, the direct oblimin oblique rotation produced only two items in Factor 1 and one item in Factors 3 and 4. Given the interpretability concerns and substantive rationale, the varimax rotation was chosen to maximize the dispersion of loadings within factors.

Multiple indices were used to determine the number of factors to retain, including the (a) Kaiser criterion of eigenvalues greater than one (Guttman, 1954), (b) scree test (Gorsuch, 1983), (c), minimum average partial (MAP) test (O'Connor, 2000), (d) parallel analysis (Horn, 1965), and (e) clear interpretability of factors with factor loadings great than .4 and at least three items per factor. An EFA of the 32 supportive situations was also conducted based on the same method and criteria as used in the problematic situations.

Ensuring Research Quality

Several procedures were used in this research to reduce bias and increase the trustworthiness of the data, as described by Padgett (2008). The primary researcher maintained an audit trail, which included documenting the process of the research as well as reflexive notes from the researcher. This allowed for a more accurate representation of changes and justifications made as well as a source of reflexivity throughout the study. Creswell (2003) also recommends ongoing reflexivity to systematically reflect on personal values that could influence the study, including self-disclosure in the analysis. Reflexivity occurred in this project from ongoing conversations with the dissertation committee overseeing the research. Additionally, critical interpretations of data included explanations for negative evidence and consideration of alternative explanations (Shek, Tang, & Han, 2005). Critically evaluating the qualitative and quantitative data allowed for a more thorough understanding of the experiences of youth.

Ensuring all IRB expectations of ethical research with human subjects was essential and considered in the design and implementation of this research project, and approvals are provided in Appendix O. Working with a vulnerable population such as former foster youth required additional considerations and sensitivity to informed consent. The initial meeting with participants included discussion of the informed consent and additional topics such as maintaining the confidentiality of their peers and conversations in focus groups. Although the requested information did not directly inquire about sensitive issues such as trauma or stigma, for example, the participants sometimes offered sensitive information as background or supporting evidence. In these cases, the young adults were allowed to share their experiences and referred back to supportive adults or agencies as appropriate. Additionally, the researcher was aware of

the importance of being sure the young adults felt free to decline or withdraw from the study at any point, taking into consideration that this population grew up in a system that at times allowed them little choice.

Chapter 4

DATA ANAYLSIS AND RESULTS

As a two-phase process, the results of the initial qualitative phase informed the development of quantitative scale to measure former foster youth's competency in navigating mental health services as they age out of foster care. Strauss and Corbin (1998) emphasize the importance of the interplay between qualitative data and quantitative measures rather than simply utilizing both methods. The results for each phase are presented individually in this section; discussion of themes and interplay of both methods will occur in Chapter 5.

Phase One Results

A convenience sample of 55 young adults filled out the initial demographic survey (see Appendix A) for recruitment, and 29 were chosen to participate in the focus groups, primarily on availability of the often difficult to reach population, but also related to diversity of location (e.g. Phoenix metro area and southern areas of the state) and placement (e.g. shelter, on their own, foster family, etc.). The mean age of participants was 19.03 years (SD = 1.35), and the mean time spent in out-of-home care was 6.43 years (SD = 5.01). In terms of race/ethnicity, the sample was 45% Caucasian (n = 13), and consistent with the population of the southwest there was also 28% Latino/Hispanic (n = 8), as well as 10% (n = 3) African American, 3 % (n = 1) American Indian, and 14% (n = 4) multiracial. Just over half of the sample (n = 15) identified as male, 45% (n = 13) as female, and one person (3%) as transgender. Consistent with the population of youth aging out in Arizona (National Youth in Transition Database, 2013), 31% of the participants (n = 9) lived in their own apartment or home, 21% (n = 6) were living with

biological family; 24% (n = 7) were in group homes, and 10% (n = 3) in shelters. One young adult remained with a foster family and one identified as not having a consistent home or was homeless. In terms of services, participants were asked what mental health services they had experienced, as well as how long they were involved if applicable. Services most often reported included individual counseling (62%, n = 18), anger management (31%, n = 9), and psychiatric medications (24%, n = 7). Other reported services included self-esteem building, art therapy, equine therapy, family counseling, crisis services, and residential treatment. Young adults participated in individual counseling an average of 4.58 years (SD = 3.68), anger management 4.89 years (SD = 2.93), and psychiatric medications for 3.54 years (SD = 3.58). Please refer to Table 1 for additional demographic information.

Table 1

Phase One Sample Description (n =29)

Variable		*M(SD)*	Frequency	Percent
Age		19.03(1.35)		
Years in Foster Care		6.43(5.01)		
Gender				
	Male		15	51.72
	Female		13	44.83
	Transgender		1	3.44
Race/Ethnicity				
	African American		3	10.34
	American Indian		1	3.45
	Asian		0	0
	White/Caucasian		13	44.83
	Latino/a or Hispanic		8	27.59
	Multiracial		4	13.79
Highest Level of Education				
	Complete some high school		9	31.03
	High school diploma		12	41.38
	GED		2	6.90
	Some college – no degree		4	13.79
	Other		1	3.45
	Missing		1	3.45
Employment				
	Full-time		12	41.38
	Part-time		2	6.90
	Not currently employed		15	51.72
Income				
	Less than $5,000		15	51.72
	$5,000-$10,000		2	6.90
	$10,000-$19,999		3	10.34
	$20,000-$29,999		2	6.90
	$30,000-$39,999		0	0
	$40,000-$49,999		0	0
	$50,000-$59,999		1	3.45
	Missing		6	20.69
Current Living Situation				
	With biological family members		6	20.69
	With foster family		1	3.45

Table 1 (continued)

In a group home		7	24.14
In a shelter		3	10.34
In my own apartment/home		9	31.03
I do not currently have a consistent home		1	3.45
Other		1	3.45
Missing		1	3.45
Mental Health Services (years)			
Individual counseling	4.58(3.68)	18	62.07
Anger management group	4.89(2.93)	9	31.03
Self-esteem building group	2.33(1.53)	3	10.34
Art therapy	10(0)	1	3.45
Equine therapy	1.33(.58)	3	10.34
Family counseling	2.67(1.53)	3	10.34
Psychiatric medication	3.54(3.58)	7	24.14
Crisis services	1.00(0)	1	3.45
Inpatient hospitalization	0	0	0
Residential treatment	6.5(4.95)	2	7

Participants in six focus groups collectively discussed 205 challenging and supportive situations. Most often, young adults discussed themes of not being included in decision-making and not feeling as though they had a voice in decisions related to their mental health services and well-being. Young adults described situations in which they did not feel that they could challenge a professional for fear of further consequences or not knowing how to address the concern. Other prominent themes were related to not feeling prepared for independent living and responsibilities such as managing appointments and changing insurance and/or providers. They also discussed situations in which they simply did not know they needed to contact their insurance company when they changed addresses to remain covered and did not find out until they went to a professional for help and were denied. Some participants also discussed adverse effects

of medications and lack of individualized services related to both medications and counseling.

Young adults who participated in the study were direct in discussing challenges they had faced and eager for their voices to be heard. They provided great specificity to situations they recognized as challenging and helpful. The participants in the focus groups often came from very different situations but all shared some similar experiences and some that were unique. All participants had very specific advice for improving services and systems of care, which was evident in their commentary. They seemed hopeful for change and that their experiences could inform improvements to mental health services for foster youth transitioning to adulthood.

The initial pool of challenging and supportive situations was reduced to 94 situations by combining similar items to more generalized experiences. Situations were intended to provide specificity but also general enough to elicit responses from a variety of individuals. Testing with a group of 20 former foster youth at a leadership conference resulted in participants taking more than the expected 20 minutes to compete the 12-page survey, with several participants asking to return the survey the following day. As discussed in Chapter 3, consensus decisions were made in consultation with the dissertation chair to further shorten the survey by removing scales and eight additional situations.

Phase Two Results

Multiple analyses were used to examine the results of the second quantitative phase, including descriptive statistics and multiple EFAs to examine the underlying dimension of the inventory. One hundred twenty-three online and 103 hard-copy surveys

were used in analysis. With the increased accessibility, 45% (n = 103) of the total surveys were completed outside the state of Arizona, spanning 22 additional states.

The quality of the data was questioned in the responses received from additional states (National sample; n = 103), with large-scale problems noted upon examination of sample demographics. Chi-square analysis suggested a significant between-group differences in gender, $x^2(42) = 64.88$, $p < .05$; the National sample was 96% male and the Arizona sample only 53%. There was also a significant association with race/ethnicity and sample, $x^2(5) = 111.76$, $p < .05$, with 98% Caucasian in the National sample versus 34% Caucasian, 21% Latino/Hispanic, 21% Multiracial, and 19% African American in the Arizona sample. The National sample was also on average was in an out-of-home or foster placement longer (M = 10.88, SE = .30) than the Arizona sample (M = 6.34, SE .45), measured in years. This difference was significant $t(222) = -8.01$, 95% CI [-5.65, -3.42], with a medium effect size of .64 (indicating the groups differed by about 2/3 of a standard deviation). In addition, 91% of the National sample was residing with a foster family, as compared with 3% of the Arizona sample.

As a result of the stark differences in samples, the National dataset was reluctantly discarded and further analyses for phase two were conducted with only the Arizona sample (n = 121). It is recognized that this decision severely limited the sample size for analysis, however the importance of data quality outweighed the potential benefit of a larger sample. The decision to not conduct comparative analyses on the national sample was made due to its homogeneity in gender (96% male), race/ethnicity (98% Caucasian), and living situation (91% residing with foster family). It is likely the group of surveys completed nationally came from attendance at a national convention serving a particular

subset of foster alumni; however, in terms of analysis, falsely low estimates of factor loadings and correlations of factors can result from use of a sample more homogenous than the larger population (Brown, 2006).

Sample. Sample characteristics of the full, National, and Arizona samples can be found in Table 2. Characteristics of the Arizona sample are presented here and will be used in subsequent analysis. The mean age of participants from the Arizona sample was 19.55 (*SD* = 1.53) and the average time spent in an out-of-home placement was 6.34 years (*SD* = 5.00). In terms of race/ethnicity, the sample was 34% Caucasian (*n* = 41), 21% Latino/a or Hispanic (*n* = 25), 21% Multiracial (*n* = 25), 19% African American (*n* = 23), and 4% American Indian (*n* = 5). Participants were primarily male (53%), although 44% identified as female and two participants identified as transgender. Forty-nine young adults (40%) had completed high school with a diploma or GED, and 27 (22%) had completed at least some college. Nearly half of the sample (48%) was working at least part-time. A third of the sample reported living in their own apartment or home (34%) and another third living in a group home or shelter (34%). Sixteen percent (*n* = 19) of the sample was living with family/friends and 12% (*n* = 14) reported not having a consistent home.

Participants were asked about mental health services they had experienced prior to turning 18 and after turning 18 (Table 3), based on questions from the Service Assessment for Children and Adolescents (SACA), (Stiffman et al., 2000). Sixty-one percent (*n* = 74) of the sample had participated in services with a professional in a private office such as a psychologist, psychiatrist, or social worker, 49% (*n* = 59) visited a community mental health center, child guidance center, or outpatient mental health clinic,

and 43% (n = 52) were prescribed medications for emotional or behavioral problems, prior to turning 18. Other services before turning 18 included hospitalization for mental health problems, substance abuse programs, and seeing a healer, Shaman, or spiritualist. After 18, reported service use decreased in all services but most notably decreased in seeing a professional in a private office (34%) and medications (26%).

Table 2

Phase Two Sample Description

Variable	Full Sample (n = 224)	National (n = 103)$_a$	Arizona (n = 121)
Age	M = 19.61(SD = 1.21)	M = 19.67(SD = .66)	M = 19.55(SD = 1.53)
Years in Foster Care	M = 8.42(SD = 4.79)	M = 10.87(SD = 3.08)	M = 6.34(SD = 5.00)
Gender			
Male	163(72.77)	99(96.11)	64(52.89)
Female	55(24.55)	2(1.94)	53(43.80)
Transgender	2(.89)	0(0)	2(1.65)
Missing	4(1.79)	2(1.94)	2(1.65)
Race/Ethnicity			
African American	23(10.27)	0(0)	23(19.01)
American Indian	5(2.23)	0(0)	5(4.13)
Asian	0(0)	0(0)	0(0)
White/Caucasian	142(63.39)	101(98.06)	41(33.88)
Latino/a or Hispanic	27(12.05)	2(1.94)	25(20.66)
Multiracial	26(11.61)	0(0)	25(20.66)
Missing	1(.45)	0(0)	1(.83)
Highest Level of Education			
Less than 8th grade	3(1.34)	0(0)	3(2.48)
Completed some high school	13(5.80)	2(1.94)	11(9.09)
Still in high school/GED	28(12.50)	0(0)	28(23.14)
High school diploma	49(21.88)	10(9.71)	39(32.23)
GED	33(14.73)	23(22.33)	10(8.26)
Some college – no degree	89(39.73)	65(63.12)	24(19.83)
Associate’s degree	5(2.23)	3(2.91)	2(1.65)
Bachelor’s degree	1(.45)	0(0)	1(.83)
Missing	3(1.34)	2(1.94)	3(2.48)
Employment			
Full-time	112(50.00)	93(90.29)	19(25.70)
Part-time	33(14.73)	6(5.83)	27(22.31)
Not currently employed	54(24.11)	0(0)	54(44.63)
Missing	25(11.16)	4(3.88)	21(17.35)
Current Living Situation			
With biological family members	9(4.02)	0(0)	9(7.44)

Table 2 (continued)

With extended family	4(1.79)	0(0)	4(3.31)
With foster family	104(46.43)	100(91.09)	4(3.31)
With friends	7(3.13)	1(.97)	6(4.96)
In a group home	22(9.82)	1(.97)	21(17.36)
In a shelter	20(8.91)	1(.97)	19(15.70)
In my own apartment/home	41(18.30)	0(0)	41(33.88)
Do not have a consistent home	14(6.25)	0(0)	14(11.57)
Missing	3(1.34)	0(0)	3(2.48)

[a] Participants in the national sample spanned 22 states: Arkansas (6), California(9), Colorado (12), Connecticut (5), Delaware (4), Florida (9), Georgia (9), Idaho (1), Illinois (4), Indiana (9), Iowa (5), Kansas (9), Kentucky (4), Maine (1), Mississippi (1), Pennsylvania (1), Texas (1), Vermont (4), Washington (4), West Virginia (2), Wisconsin (1), and Wyoming (1).

Table 3

Phase Two Mental Health Services (n = 121)

Service	Prior to 18	After 18
	Mean (SD)	*Mean (SD)*
A community mental health center, child guidance center, or outpatient mental health clinic	59(48.76)	37(30.58)
A professional in a private office like a psychologist, psychiatrist, social worker, or counselor	74(61.16)	41(33.88)
A healer, Shaman, or spiritualist	2(1.65)	3(2.48)
Substance abuse treatment program/group	16(13.22)	13(10.74)
Hospitalization for mental health problems	22(18.18)	17(14.05)
Medication for emotional or behavioral problems	52(42.98)	31(25.62)

Frequencies and intensities. Descriptive statistics were computed regarding the most frequent and intense situations encountered by former foster youth. Mean scores ranged from 2.53 to 1.52, on the four point Likert-type scale, indicating the young adults experienced some difficulty with all situations and moderate difficulty on others. (Appendices G and H list mean scores for both intensity and frequency for challenging situations in totality.) When depicted as mean scores of frequency, nine out of 10 of the most challenging situations were also rated as the most frequently encountered. As a result, the mean scores of intensity and frequency were combined and the top ten most distressing situations are presented in Table 4. Two of the most difficult situations rated by participants in this study were, "You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first" (M = 5.55, SD = 2.50), and "You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18" (M = 5.23, SD = 2.54), which speak to the interacting and overwhelming nature of responsibilities after turning 18. Other

themes of the top ten most distressful included wanting more voice and choice, the stigma of being involved in care, and receiving mixed messages as the most difficult situations encountered as they turned 18.

Recognizing that the scale of frequency used in the inventory ('1-2 times a day,' '1-2 times a week,' '1-2 times a month,' '1-2 times a year,' and 'never') does not represent equidistant timeframes, the results of frequency ratings are also presented in totality in Appendix I. Figure 2 summarizes the 15 most frequently encountered challenging situations, sorted by those occurring daily, weekly, or monthly, as compared to annually or never. The situation "Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you," was reported as the occurring once or twice monthly, weekly, or daily for more than 60% of respondents. Along with having too much to focus on after 18, situations of stigma and mixed messages came up again. Forty-two percent of respondents reported that "Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you," occurred at least once or twice a month. More than 50% of respondents reported experiencing the situation "Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care," at least once or twice a month.

Table 4

Combined top ten most intense and frequently encountered difficult situations for former foster youth (n =121)

	Frequency		*Intensity*		*Total Mean Score*	
Situation	Mean	SD	Mean	SD	Mean	SD
You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	2.53	1.03	3.02	1.47	5.55	2.50
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	2.46	0.98	2.81	1.21	5.27	2.19
You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	2.41	1.08	2.82	1.46	5.23	2.54
Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	2.37	1.17	2.68	1.44	5.05	2.61
Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	2.29	1.21	2.63	1.57	4.92	2.78
You have a hard time trusting professionals because they change so frequently.	2.37	1.12	2.50	1.42	4.87	2.54
You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	2.21	1.09	2.59	1.44	4.80	2.53
When you did contact people for help, you received mixed messages from different people, which left you confused.	2.34	1.14	2.46	1.40	4.80	2.54
Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	2.25	1.17	2.51	1.53	4.76	2.7
After refusing to take your medications while in care, you were told privileges would be taken away if you refused to comply.	2.24	1.19	2.44	1.50	4.68	2.69

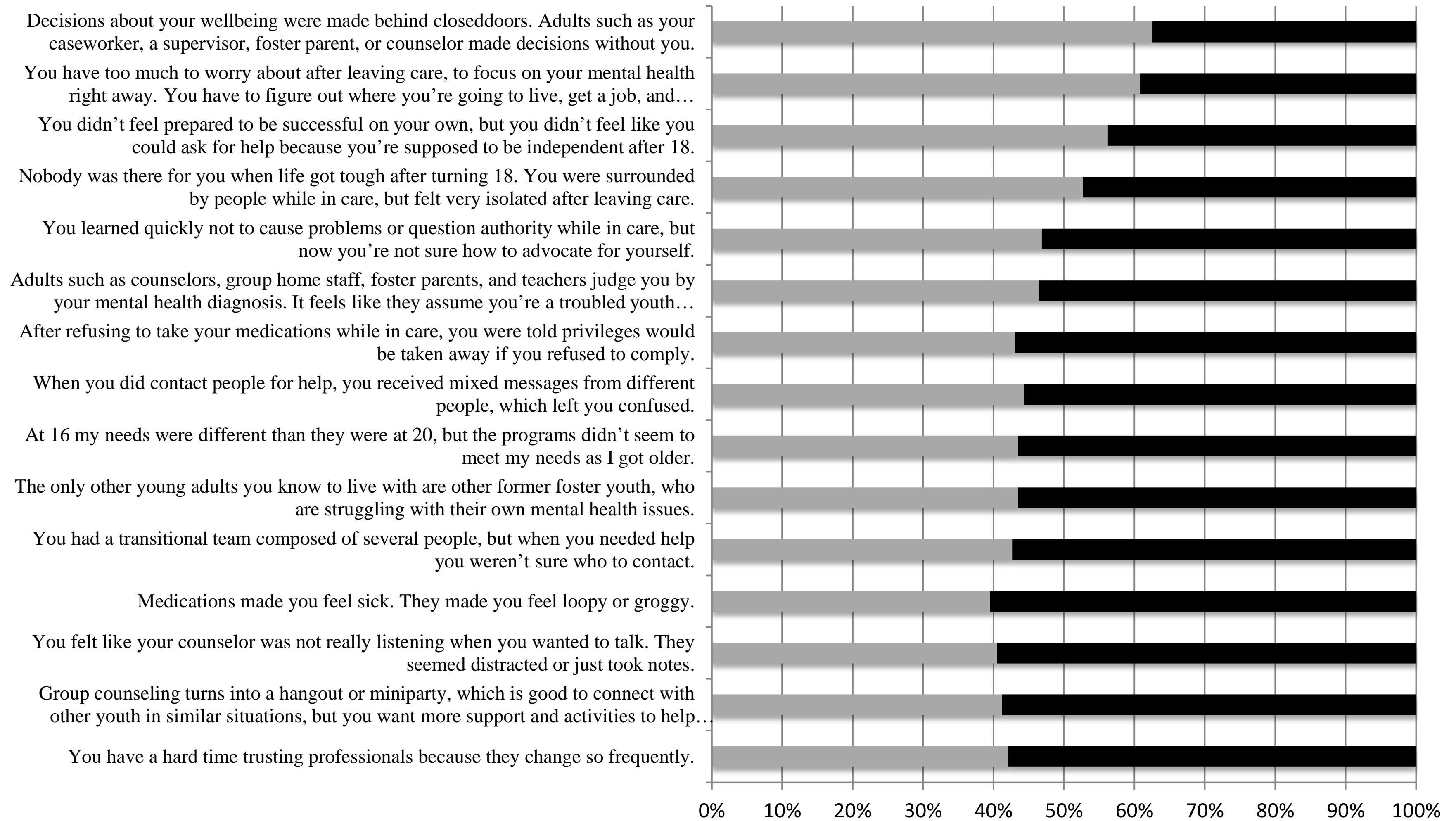

Figure 2. Top 15 most frequently encountered challenging situations, represented by daily/weekly/monthly (gray) and annually/never (black) (*n* 121).

Supportive frequencies and intensities. Although the intensity of supportive situations was measured on a similar four-point Likert-type scale as the challenging situations, mean scores for the most supportive situations were a bit higher, ranging from 1.60 to 2.98 (Appendix J). The supportive situations with the highest mean scores for frequency of encountering the situations were again very similar to those situations with the highest intensity mean scores. Nine out of 10 most frequently encountered supportive situations were also the most helpful, according to respondents (Appendix K). Mean scores were combined for frequency and intensity in Table 5 to represent the most useful situations former foster youth encountered with mental health as they transitioned to adulthood. Five of the 10 most useful situations young adults reported were related to mentorship and social support. For example, “You have someone to call if things get really tough. You have a person who listens and gives you advice” had an average score of 6.38 (*SD* = 2.48), and “You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions” had a combined mean score of 5.53 (*SD* = 2.52), indicating these are situations very helpful as foster youth transition.

Other highly rated situations were related to breaking down tasks and helping them prepare for adult roles, including “An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process” (*M* = 5.39, *SD* = 2.42). Situations related to gaining perspective and self-efficacy were also rated as helpful. For example, situations of “You get to bond with other youth/young adults experiencing similar situations at programs,” and “Once you were on your own, you were able to make decisions and allowed to make mistakes. You

learned from them and were able to decide what was best for you," had combined mean scores of 5.81 (*SD* = 2.49) and 6.17 (*SD* = 2.29), respectively. Examination of individual frequency scores of situations in Figure 3, depicts than more than 70% of young adults indicated "You have someone to call if things get really tough," and 78% reported "You get to bond with other youth/young adults experiencing similar situations at programs," at least once or twice a month. These results seem to suggest the most helpful situations are those in which former foster youth are most frequently engaging. A complete listing of individual frequencies reported for supportive situations can be found in Appendix L.

Table 5

Combined top ten most intense and frequently encountered supportive situations for former foster youth (n =121)

	Frequency		*Intensity*		*Total Mean Score*	
Situation	Mean	SD	Mean	SD	Mean	SD
You have someone to call if things get really tough. You have a person who listens and gives you advice.	2.98	1.03	3.4	1.45	6.38	2.48
Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	2.69	0.95	3.48	1.34	6.17	2.29
You get to bond with other youth/young adults experiencing similar situations at programs which was helpful.	2.79	1.08	3.02	1.41	5.81	2.49
You maintain your mental health by using distractions such as school, work, or other activities.	2.68	1.08	3.08	1.57	5.76	2.65
Having leadership opportunities helped you gain perspective with your own mental health.	2.8	1.07	2.95	1.38	5.75	2.45
You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	2.52	1.11	3.01	1.41	5.53	2.52
Teachers or coaches at your school provided emotional support and encouraged you.	2.53	1.07	2.98	1.43	5.51	2.5
It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	2.52	1.07	2.89	1.45	5.41	2.52
An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	2.62	1.04	2.77	1.38	5.39	2.42
You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	2.46	1.11	2.79	1.47	5.25	2.58

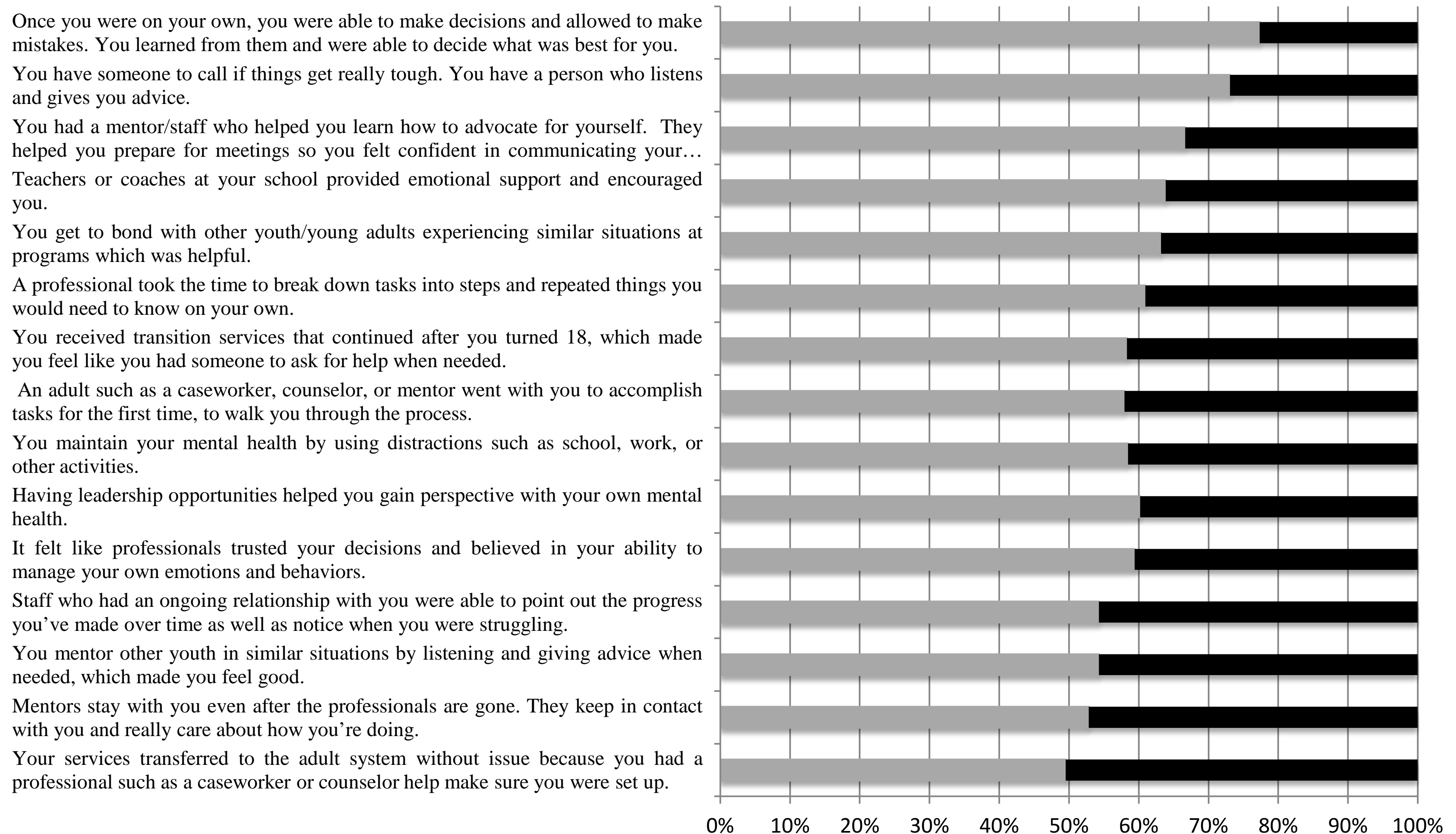

Figure 3. Top 15 most frequency encountered supportive situations, represented by daily/weekly/monthly (gray) and annually/never (black) (*n* 121).

EFA Results. In addition to examining the frequencies of the situations presented in the inventory, EFAs were conducted on both the challenging and supportive situations to determine underlying factor structures. As previously mentioned, the 15 challenging situations specific to medications were evaluated separately and will be discussed in the following section. An EFA was conducted on the remaining 39 challenging situations. Initial examination of the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy to be .84, which provides confidence that the sample size (n = 121) was adequate for factor analysis (Field, 2009). In addition, Bartlet's test of sphericity was significant, $x^2(741) = 2272.10$, $p < .001$, indicating the R-matrix is not an identity matrix; therefore, factor analysis is considered appropriate as there are relationships between the included variables.

Problematic situations. Results of the challenging situation EFA were somewhat difficult to interpret because the five indices used to determine the number of factors produced divergent findings. The Kaiser criterion of eigenvalues greater than one (Table 6) indicated nine factors. The scree plot indicated three or seven factors (Figure 4) and parallel analysis indicated three (Figure 5). The original (Velicer, 1976) MAP test extracted three factors and the revised (Velicer, Eaton, & Fava, 2000) MAP test extracted only two (O-Conner, 2000). The maximum likelihood goodness of fit test was also non-significant at 12 factors [$x^2(339) = 372.31$, $p = 1.03$], suggesting there could be as many as 12 factors. Clear interpretability of factors was given considerable weight, including elimination of factor loadings less than .4 and those with less than three loadings per factor. Based on these criteria, one could estimate as few as two or as many as 12 factors.

Table 6

Eigenvalue plots and total variance explained for 39 challenging situation items

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	16.79	43.06	43.06	8.76	22.47	22.47	4.52	11.58	11.58
2	2.53	6.48	49.53	3.27	8.38	30.84	4.46	11.43	23.00
3	2.05	5.25	54.78	5.26	13.48	44.32	4.29	10.99	33.99
4	1.58	4.06	58.83	2.78	7.12	51.44	3.20	8.21	42.20
5	1.44	3.70	62.54	1.33	3.40	54.83	2.50	6.42	48.62
6	1.38	3.54	66.07	1.91	4.90	59.73	2.25	5.78	54.40
7	1.23	3.15	69.22	1.16	2.97	62.70	2.19	5.61	60.01
8	1.12	2.86	72.08	1.03	2.65	65.35	1.70	4.35	64.37
9	1.03	2.64	74.72	0.84	2.15	67.49	1.22	3.13	67.49
10	0.95	2.45	77.17						
11	0.83	2.14	79.31						
12	0.79	2.03	81.34						
13	0.69	1.77	83.11						
14	0.64	1.65	84.76						
15	0.57	1.46	86.22						
16	0.56	1.42	87.64						
17	0.51	1.32	88.96						
18	0.45	1.16	90.11						
19	0.38	0.98	91.09						
20	0.37	0.96	92.05						

Table 6 (continued

21	0.37	0.94	92.99
22	0.36	0.92	93.91
23	0.31	0.80	94.71
24	0.26	0.67	95.38
25	0.24	0.61	95.99
26	0.23	0.59	96.58
27	0.22	0.56	97.14
28	0.18	0.47	97.61
29	0.17	0.43	98.04
30	0.13	0.34	98.37
31	0.12	0.30	98.67
32	0.11	0.28	98.95
33	0.09	0.24	99.19
34	0.08	0.19	99.39
35	0.06	0.16	99.54
36	0.05	0.14	99.68
37	0.05	0.14	99.82
38	0.05	0.11	99.93
39	0.03	0.07	100.00

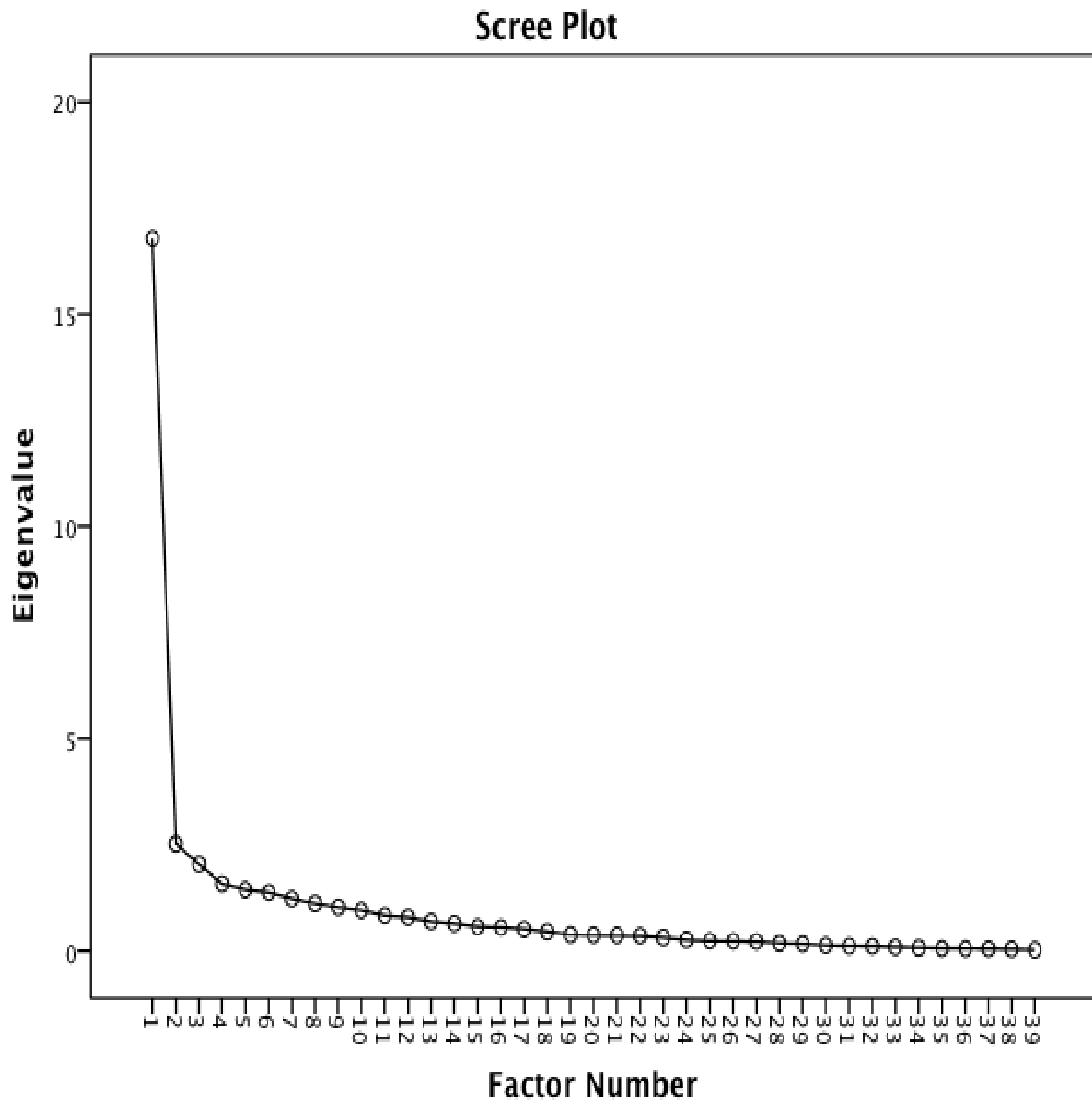

Figure 4. Scree plot supporting a three or seven factor solution for challenging situations.

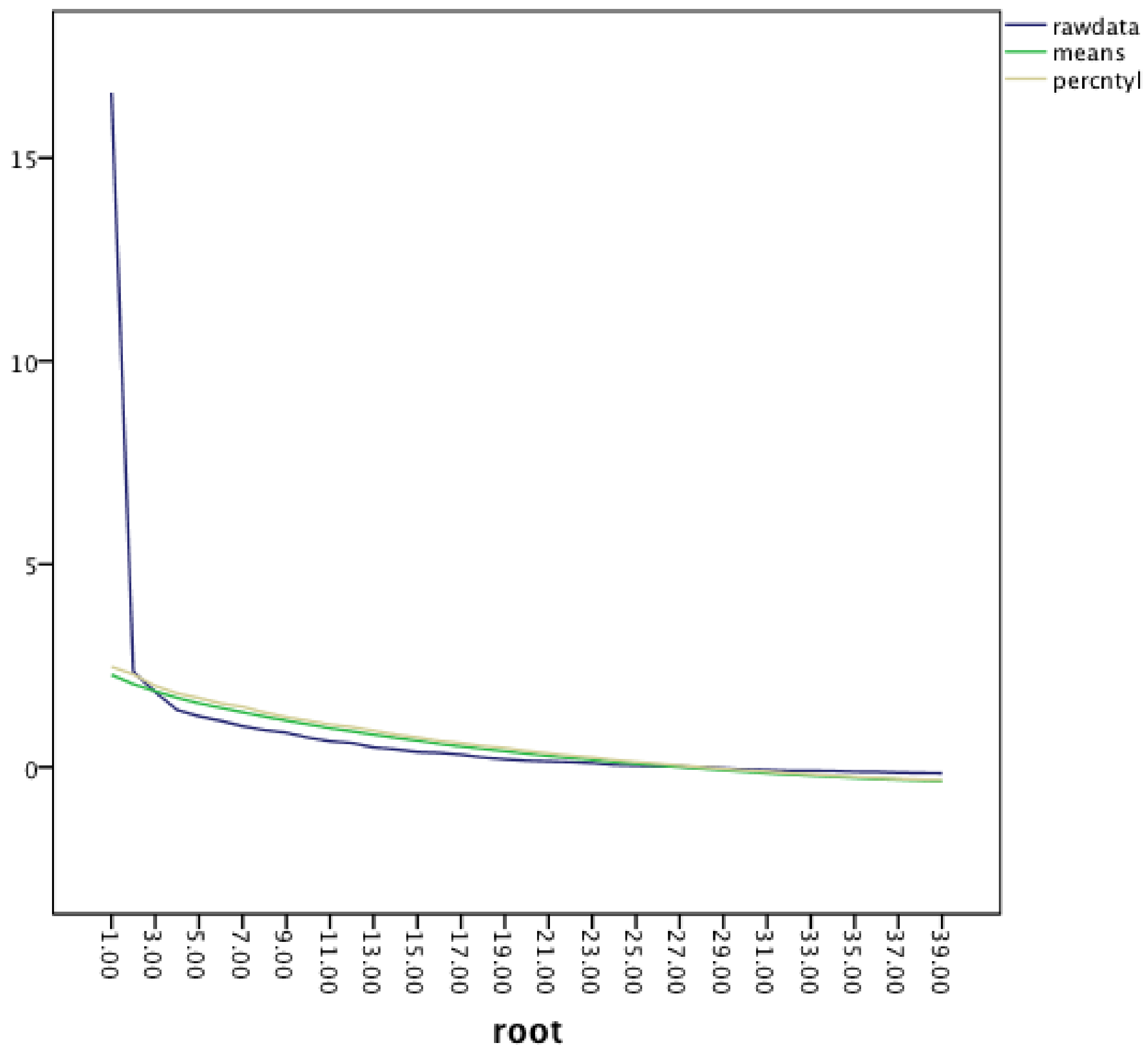

Figure 5. Parallel analysis plot supporting a three-factor solution for challenging situations.

Each of the previous criteria contribute to making an informed decision of number of factors and reasonable fit. Each criteria presents its own set of concerns and as demonstrated by the variance in results, no single criteria should be used alone. The Kaiser criterion, scree plots, and parallel analysis have been criticized for being arbitrary and subjective (Fabrigar, Wegener, MacCallum, & Strahan, 1999; Preacher & MacCallum, 2003), and have demonstrated both under- and over-estimations of factors

(e.g. Buja & Eyuboglu, 1992; Cattell & Vogelmann, 1977; Zwick & Velicer, 1986). In these data, the first four factors have eigenvalues of 8.76, 3.27, 5.26, and 2.78, explaining 55% of the variance. The subsequent eigenvalues of 1.33, 1.91, 1.16, and 1.03 offer an additional 14% of variance explained, which is debatable if useful and unclear as to which factors to add. The scree plot of these data could be interpreted as three or seven factors; the biggest change in direction is between factors three and four, however the plot levels off again after factor seven.

The parallel analysis was also relatively ambiguous because the raw data and 95th percentile lines cross at factor three, but then cross again around 25. MAP tests extracted two and three factors in this analysis, but MAP tests have demonstrated under-estimation of factors with few items or low loadings (Zwick & Velicer, 1986). The maximum likelihood goodness of fit test indicated there could be up to 12 factors, but studies have also shown it to over-estimate factors (Field, 2009). Research suggests that over-estimating factors is less severe in introducing error to factor loading estimates, although avoiding both would obviously be optimal (e.g. Fava & Velicer, 1992; Wood, Tataryn, & Gorsuch, 1996).

All indices were taken into consideration but clear interpretability of factors was given considerable weight in the final determination. Ultimately, the solution for this analysis was 26 items comprising 5 factors, based on the following rationale (factors and loadings presented in Table 7). Factor 1 had 10 items loading greater than .4, which seemed to be related to receiving mixed messages (MM). Items such as "Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out," and "Staff told you to avoid the negative stereotypes of youth

aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them," suggest young adults are uncertain how to handle situations. Other situations were specific to not knowing who to contact, difficulty trusting people, and receiving stricter consequences than peers.

Factor 2 was interpreted as not having a choice or voice (CV), with five items. Situations such as "You were kicked out of where you lived because of symptoms related to your mental health," and "You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services," communicated abruptly made decisions in which they young adult had little if any choice. Other situations of "You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18," and "You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns," communicate not having a say or not feeling like they knew what to say when making decisions. A sixth item, "You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse," could be interpreted as not feeling like they had any other options but to turn to drugs or alcohol; however, it's rather circumstantial in this regard and was dropped from the factor.

Factor 3 had eight items loading, although two cross-loaded and fit better conceptually with Factor 1 and a third, "Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments," also did not fit as well conceptually with the remaining items, so was dropped. The remaining five items were related to accessing services (AS). Situations

related to losing pay at work to make appointments, not having consistent transportation, and having to switch providers after turning 18 seemed to be systemic barriers for young adults in accessing services. Factor 4 consisted of three items related to feeling overwhelmed with responsibilities and expectations of being independent after turning 18 (OV). Situations were specific to the ecological and interacting stressors after turning 18 which impacted mental health, such as "You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first." The other two situations are related to not feeling like they can ask for help or isolated with no one to turn to after 18.

The three items loading on Factor 5 were interpreted as looking for an identity or support beyond foster care/child welfare (ID). The situations of "You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system," and "Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills," indicate young adults are seeking to move beyond shared experience and being associated with the foster care system. The other situation, "The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues," also speaks to having relationships primarily with other foster youth which can be limiting if both are struggling. These five factors explained 48.62% of the total variance.

Table 7

Factor solution loadings based on a principle factor extraction analysis with varimax rotation for the supportive situations (n = 121)

Factor	Item	Situation	Coefficient
Mixed Messages	MM1	When you did contact people for help, you received mixed messages from different people, which left you confused.	.45
	MM2	Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	.49
	MM3	You have a hard time trusting professionals because they change so frequently.	.43
	MM4	You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	.48
	MM5	Professionals may have discussed how to return to services after 18 if you decided you needed help, but you didn't remember what they told you to do or who to contact when you actually needed help.	.85
	MM6	Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	.50
	MM7	Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	.42
	MM8	It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	.56
	MM9	At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	.57
	MM10	A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	.49
Choice/Voice	CV1	Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	.73
	CV2	You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	.77
	CV3	You were kicked out of where you lived because of symptoms related to your mental health.	.75
	CV4	You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	.41

Table 7 (continued)

	CV5	You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	.40
Accessing Services	AS1	At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	.43
	AS2	You didn't continue mental health services after turning 18 because you would lose pay for missing work.	.51
	AS3	You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	.53
	AS4	You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	.58
	AS5	You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	.60
Overwhelmed	OV1	You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	.62
	OV2	Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	.80
	OV3	You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	.77
Identity/ Beyond Care	ID1	The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	.45
	ID2	You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	.44
	ID3	Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	.50

Challenging medication situations PCA. As previously mentioned, the challenging medication questions were removed from the initial EFA analysis. However, when frequencies of overall problematic questions were computed, two medications questions were in the 10 most frequently encountered situations, suggesting their importance of inclusion in the overall factor solution. As a result, a principal component analysis (PCA) was conducted to separately evaluate the 15 medication items for the sub-sample reporting psychiatric medication use before or after turning 18 (n = 42), to reduce the items to be considered as an additional factor in the overall EFA and model.

Oblique rotation was used for the PCA to differentiate between factors. The KMO measure of sampling adequacy was .83 and Bartlett's Test of Sphericity was significant, $X^2(15) = 72.03$, $p < .001$, supporting the use of factor analysis and an adequate sample. Eigenvalue plots suggested factor solutions for up to 4 factors, which was reduced by removing items with multiple correlations less than .3 and anti-image matrix scores below .5. Only factor loadings great than .4 were used. Based on these criteria, analysis of the challenging medication situations yielded cohesive six items explaining 51% of the total variance (Table 8). Factor loadings are listed in Table 9. The factor included situations related to uncertainty, adverse effects, and a power differential which impacted decisions of participants in this study.

Table 8

Eigenvalue plots and total variance explained for six challenging medication situation items

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.05	50.89	50.89	3.05	50.89	50.89	3.05	50.89	50.89
2	.80	13.39	64.28				.803	13.39	64.28
3	.68	11.37	75.65				.682	11.37	75.65
4	.56	9.40	85.05				.564	9.397	85.05
5	.49	8.10	93.15				.486	8.099	93.15
6	.41	6.85	100.00				.411	6.850	100.00

Table 9

Factor loadings based on a principle component analysis with oblimin rotation for the challenging medication situations (n = 42)

Factor	Item	Situation	Coefficient
Medications[a]	MD1	It's hard for you to ask for any services or help because you're afraid you will just be put back on medications.	.76
	MD2	The doctors thought you were taking your medications, but you were not. They comment on the positive changes they've seen as a result of your medication.	.75
	MD3	Some medications helped calm you down, but they made you sleepy in school so you'd have to take another medication to wake you up.	.74
	MD4	Medications made you feel sick. They made you feel loopy or groggy.	.71
	MD5	If you complained about your medications or disagreed with the doctor, you were prescribed more medications or higher doses of ones you were already taking.	.70
	MD6	You took too many medications and ended up in the hospital. Mental health providers felt it was a substance abuse issue but substance abuse providers thought it was a suicide attempt. Neither one wanted to help you.	.62

[a] Medication situations analyzed separately as one factor, but included as a sixth factor of the overall solution.

Cronbach's alpha was used to evaluate internal consistency of the 26-items (α = .94), as well as the six factors individually (Table 10). The mixed messages subscale demonstrated reliability score of .91, and the choice/voice, accessing services, and overwhelmed subscales were .80, .81, and .82, respectively. The medication subscale had a Cronbach's alpha of .81, and the identity subscale was .63. Researchers often indicate .7 to .8 as acceptable values for internal consistency (Field, 2009); however caution should be used in interpretation of internal consistency, as Cronbach's alpha can vary by the number of items on the scale (Cortina, 1993), and is sometimes relied upon even when the underlying assumptions do not hold up in practice (Green & Yang, 2009).

Table 10

Subscale Reliability Analysis of Challenging Situations

	Arizona Sample (n = 121)			Full Sample (n = 224)		
	Reliability Coefficient	*M*	*SD*	Reliability Coefficient	*M*	*SD*
Overall (32 items)	.96	62.85	23.36	.93	66.52	17.62
Subscales						
Mixed messages (10 items)	.91	21.65	8.64	.85	21.93	6.50
Medications (6 items)	.83	11.03	4.83	.74	11.96	3.88
Overwhelmed (3 items)	.82	7.29	2.84	.70	6.86	2.32
Accessing services (5 items)	.81	9.71	4.24	.70	10.25	3.32
Choice/voice (5 items)	.80	8.75	3.94	.71	9.93	3.32
Identity/support beyond care (3 items)	.63	5.91	2.47	.60	6.42	2.18

Supportive situations EFA. Prior to conducting the EFA on the supportive situations, the two supportive situations referencing medications were inspected and found to have the same error in response as the medication questions in the challenging situations, so they were also removed from analysis. Because there were only two questions related to medications, there was not enough to potentially add a medication factor back into the overall model. An EFA was conducted on the remaining 30 supportive situations. Initial examination of the analysis provided the KMO measure of sampling adequacy to be .69, which is still satisfactory to conduct factor analysis. Bartlet's test of sphericity was also significant, $x^2(435) = 1370.47$, $p < .001$, indicating there are relationships between included variables, supporting factor analysis as well.

Maximum likelihood extraction was initially chosen as it provided the best fit for the problematic situation EFA, however the items loading highly on the same components did not differentiate well, theoretically. For example, Factor 1 was comprised of 10 factors loading greater than .4. Six of the situations appeared to be related to ongoing social support during the transition, such as "Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed

you a chance to make more independent decisions while still being supported," and "You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you." The remaining four situations seemed to focus more on initiative and self-efficacy, including situations such as "You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18," and "You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you." Only the oblique rotation produced interpretable results with the maximum likelihood extraction.

Principle factor analysis with an orthogonal rotation provided a clearer delineation of factors for the supportive situation EFA, producing a final solution of four factors and 17 items. The Kaiser criterion of eigenvalues greater than one (Table 11) indicated nine factors explaining 56.95% of the variance. This number was quickly reduced to no more than seven factors, by using only factor loading greater than .4 and those with at least three items per factor. The scree plot also indicated two or six factors (Figure 6). Use of the principle factor analysis did not allow for the additional indices of fit that were used with the maximum likelihood rotation. Clear interpretability of factors determined the final solution of four factors, confirmed when potential factors five through nine ended up with only two items loading greater than .4 (factors and loading presented in Table 12).

Table 11

Eigenvalue plots and total variance explained for 30 supportive situation items

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.29	24.31	24.31	4.10	13.68	13.68	4.21	14.05	14.05
2	2.77	9.22	33.52	0.93	3.10	16.78	1.85	6.18	20.23
3	2.26	7.53	41.06	1.87	6.22	23.00	1.70	5.68	25.91
4	1.93	6.45	47.50	3.54	11.78	34.78	1.67	5.57	31.48
5	1.59	5.31	52.81	2.10	6.99	41.77	1.66	5.52	37.00
6	1.37	4.58	57.39	1.68	5.59	47.36	1.57	5.25	42.25
7	1.21	4.04	61.43	1.03	3.42	50.78	1.54	5.12	47.37
8	1.11	3.71	65.14	1.15	3.84	54.62	1.44	4.79	52.16
9	1.03	3.43	68.57	0.70	2.33	56.95	1.44	4.79	56.95
10	0.93	3.11	71.68						
11	0.86	2.86	74.53						
12	0.81	2.70	77.24						
13	0.76	2.53	79.77						
14	0.70	2.33	82.10						
15	0.65	2.16	84.26						
16	0.55	1.84	86.11						
17	0.51	1.71	87.82						
18	0.49	1.63	89.45						
19	0.42	1.42	90.86						
20	0.39	1.30	92.16						
21	0.37	1.22	93.39						
22	0.34	1.14	94.52						

Table 11 (continued)

23	0.34	1.13	95.65
24	0.33	1.09	96.74
25	0.25	0.84	97.58
26	0.18	0.61	98.19
27	0.17	0.55	98.74
28	0.15	0.51	99.25
29	0.14	0.46	99.71

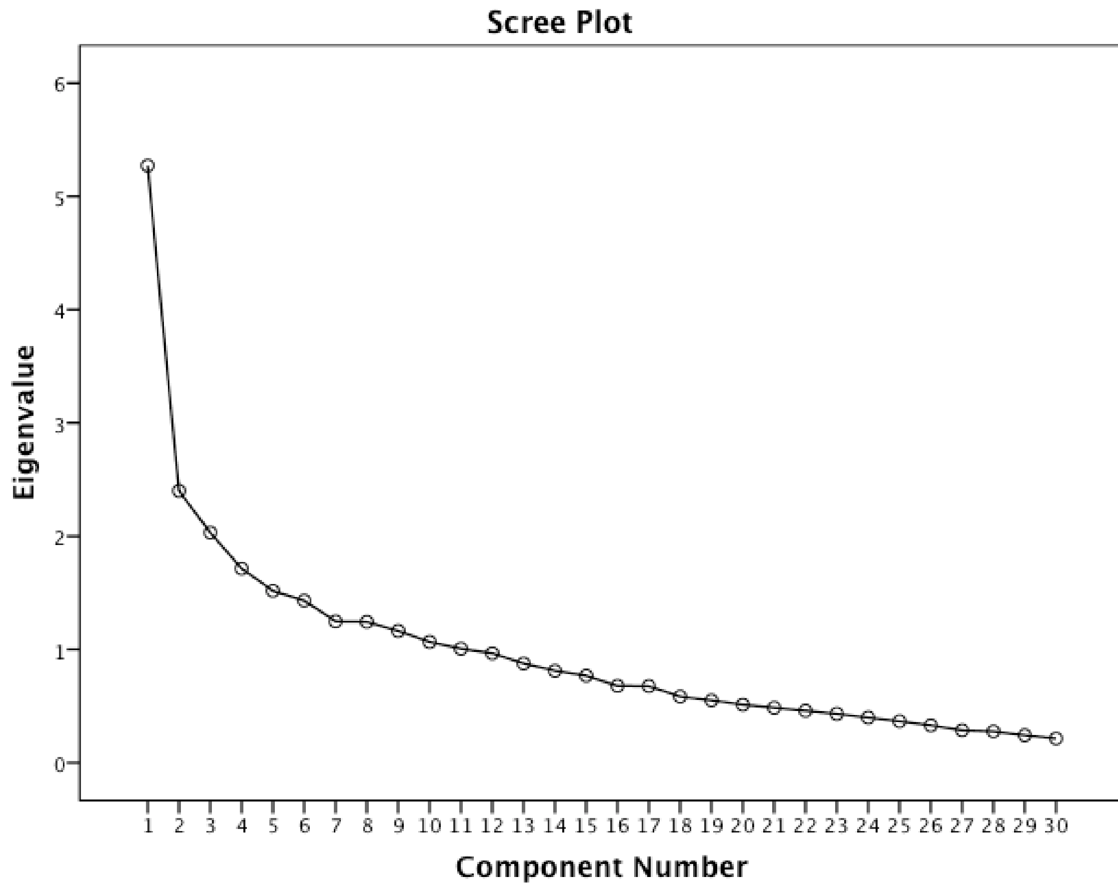

Figure 6. Scree plot supporting a two or six factor solution for supportive situations.

Table 12

Factor loadings based on a principle component analysis with oblimin rotation for the challenging medication situations (n = 42)

Factor	Item	Situation	Coefficient
Responsive engagement	RE1	A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	0.61
	RE2	Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	0.47
	RE3	An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	0.78
	RE4	You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	0.65
	RE5	It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	0.74
	RE6	Teachers or coaches at your school provided emotional support and encouraged you.	0.44
	RE7	You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	0.56
Consistency in service transitions	ST1	You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	0.49
	ST2	You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	0.43
	ST3	Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	0.72
Ongoing mentorship	OM1	Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	0.51
	OM2	Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	0.47
	OM3	You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	0.69

Table 12 (continued)

Self-efficacy	SE1	You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	0.49
	SE2	You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	0.41
	SE3	Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	0.50
	SE4	You maintain your mental health by using distractions such as school, work, or other activities.	0.58

Factor 1 had seven items loading greater than .4, which seemed to be related to responsive engagement (RE). Situations included in this factor described professionals and mentors who "break down tasks into steps and repeated things you would need to know on your own," and "went with you to accomplish tasks for the first time, to walk you through the process," demonstrated their commitment to meeting the young adults' developmental and emotional needs related to transitions. Other situations spoke to feelings that adults trusted their decisions and encouraged them through emotional support. Helping young adults learn to advocate for themselves by practicing and preparing to communicate effectively, was important to participants in this study and demonstrates the need to go beyond social support, to consider the importance of genuine engagement and responding to the individual needs of young adults.

The three items in Factor 2 are similar in describing consistency and support through service transitions (ST), with situations such as "You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you." Other situations were specific to transferring services, having someone help ensure services were set up and feeling as though there was someone to ask for help when needed, as a result of having transition-specific services. These situations speak to the importance of formal relationships and services during the transition to adulthood for those foster youth who want to continue mental health services after 18.

The third factor also had three items, interpreted as ongoing mentorship (OM). Situations describe "mentors [who] stay with you even after the professionals are gone," and "You still talk to your group home staff or foster parents, even though you've left." These situations provide that maintaining relationships with supportive adults after

turning 18, and whether they decide to continue or discontinue services, was important for many participants. The value of these relationships was described as "Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling."

The final factor in the model had four items, related to self-efficacy (SE). Items in this factor seem to be related to the participant's belief in their own ability to maintain their mental health, whether that included mental health services or not. For example, the situation "You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you," speaks to a feeling of control in decision-making that is similar to another situation describing the decision to discontinue services, "You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors." These situations may differ in method of maintaining mental health, but both speak to the importance of feeling as though young adults were able to decide what was best for them. The decision to continue or discontinue services may be more individually based on feelings of self-efficacy and empowerment in decision-making, as described in the situation "once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you."

Evaluation of the internal consistency of the 17-items produced a Cronbach's alpha of .86 (see Table 13). Individually, the responsive engagement subscale was .82, however the additional subscales of consistency through service transitions, ongoing mentorship, and self-efficacy produced lower results (α = .62, .64, and .31,

respectively). Examination of the item-total statistics for the subscales showed little difference in values of responsive engagement, service transitions, and ongoing mentorship scales, indicating all items were positively contributing to the overall reliability for each subscale. However, the values for the self-efficacy scale ($\alpha = .31$) indicated a fairly substantial increase in reliability coefficient of the subscale if the item "You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you" was removed from the factor. The internal consistency would increase from .31 to .58 in the Arizona sample and from .19 to .46 with the full sample, which may suggest a three-item subscale and an overall model of 16 items.

As mentioned previously, caution should be used in interpretation of internal consistency. In this case, estimates may be unstable as there was a smaller sample. The KMO statistic was interpreted that the sample size was adequate for factor analysis, however it is still recognized to be smaller than desired which likely impacts the reliability of the subscales. It is also possible that there is bias related to a mispecified model (Green and Yang, 2009). Although interpretation and conceptual fit are paramount in determination of factors, continued manipulation of data presents its own issues of potential bias. There are clearly many nuances to social support, which this research attempts to demarcate. Further testing with a larger sample seems to be the most pragmatic method to reassess model fit.

Table 13

Subscale Reliability Analysis of Supportive Situations

	Arizona Sample (n = 121)			Full Sample (n = 224)		
	Reliability Coefficient	*M*	*SD*	Reliability Coefficient	*M*	*SD*
Overall (17 items)	.84	40.20	10.05	.80	38.62	7.84
Subscales						
Responsive engagement (7 items)	.82	17.01	5.20	.73	15.99	4.13
Consistency in transitions (3 items)	.62	6.64	2.42	.47	6.49	1.98
Ongoing mentorship (3 items)	.64	7.06	2.51	.53	6.76	7.08
Self-efficacy (4 items)	.31	9.82	2.52	.19	9.50	2.09
(If item SE2 deleted)						
Self-efficacy (3 items)	.58	7.57	2.41	.46	7.36	1.98
Overall model (16 items)	.85	38.00	9.62	.79	36.49	7.47

Chapter 5
DISCUSSION

This study was designed to examine the situations young adults encounter as they turn 18 and transition from child welfare and children's mental health systems. The primary research question was: As youth age out of foster care, what perceived barriers and supports exist in meeting their mental health needs? The specific aims were to explore the self-identified mental health needs of former foster youth, to identify problematic situations they encounter in meeting these needs, strengths and supports they find helpful, and to determine the most frequent and intense barriers and supports encountered when navigating the mental health system. The study was intended to create an opportunity for former foster youth to communicate their experiences and needs related to mental health functioning and service utilization, to better understand their decision-making processes.

Previous research has identified general reasons for discontinuing mental health services after aging out (e.g. Courtney et al., 2011; McMillen & Raghavan, 2009); what is less understood are the specific barriers hindering progress and access to services, as well as supports facilitating mental health and effective services. This research identified specific situations identified from focus groups and interviews and tested them with a larger sample to determine the most intense and frequently encountered situations. Several themes emerged from the focus groups, which were corroborated in the second phase as factors impacting mental health experiences as youth age out of foster care.

Overwhelming expectations

Transitioning to adulthood is difficult for many youth, with increased responsibilities and changing social roles. Many participants in this study described and

highly rated challenging situations of feeling overwhelmed with managing their mental health after leaving foster care, in addition to other contextual considerations. Consistently, young adults referred to situations in which they "have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money first." Poor outcomes for former foster youth have been well-documented (e.g. Courtney et al., 2011; Scannapieco et al., 2007); however little research has examined the ecological interaction of such outcomes. Young adults in this study articulated that they struggle to focus on just one aspect of independent living because they have to prioritize and often feel overwhelmed with the process. Absence of stable contextual supports such as housing, education, and employment can negatively impact mental health after aging out (Fowler et al., 2011), which is consistent with the situations rated as most distressful in this study.

Participants reported feeling societal pressure to be successfully independent upon turning 18, but also felt pressure from themselves to manage their situation. In fact, the third most challenging situation rated by participants was "You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18." This finding contradicts previous research on emerging adulthood (Arnett & Tanner, 2006; Cohen, Kasen, Chen, Hartmark, & Gordon, 2003), which describes the societal shift in expectation for a gradual transition to adulthood characterized by ongoing social and financial support. During emerging adulthood, most youth receive family support to help them weather the difficulties associated with transitioning to independence. When foster youth age out of the child welfare system, they confront the challenges associated with this developmental stage

and are at risk of having to transition without family support or the opportunity for a gradual transition.

Participants in the study highly rated the supportive situations "An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process," and "A professional took the time to break down tasks into steps and repeated things you would need to know on your own." Antle, Johnson, Barbee, and Sullivan (2009) describe the need for a shift from providing independent living services to youth aging out of foster care, to a focus on interdependent living, to better prepare foster youth for adult responsibilities in a more gradual manner. Transitioning from a system that often requires their dependence to an abrupt societal expectation of independence was difficult for many participants in this study. Developing problem-solving skills supports mental health by lessening the likelihood of feeling overwhelmed and improving their ability to seek help when needed. Assessment of mentoring programs for older foster youth also provides that focus on task-oriented activities such as how to access services with hands-on experience is beneficial and contributes to positive outcomes (Osterling & Hines, 2006).

Mixed messages/trust

Along with overwhelming expectations, young adults in this study often described receiving confusing, inconsistent messages from service providers and agencies with whom they interacted. In the first phase of this study, participants consistently provided examples of receiving mixed messages which left them uncertain in making decisions. Not surprisingly, these situations came out as a factor in the second phase as well. Young adults described situations in which staff were available when they were in trouble or

crisis but were difficult to reach when they sought them out. They also discussed having multiple professionals on their treatment teams, but received different messages from them or were not sure whom to contact when they needed help. These examples provide insight to the confusion many foster youth experience, even when they have professional supports in place. Previous literature describes negative experiences and attitudes towards professional impacting mental health service use (e.g. Del Mauro & Williams, 2012; Rickwood, Deane, Wilson, & Ciarrochi, 2005), but the current study adds depth to these findings by illustrating specific situations which prompted negative experiences. It also demonstrates that just having services and supports in place does not mean the young adults feel supported and know how to seek help.

Participants in this study also struggled with situations in which they were told one thing but experienced something different. For example, a commonly reported challenging situation for former foster youth was when "A counselor promised what you said in session was confidential, however your caseworker and other members of your team always knew what was said." Young adults brought up several similar examples in focus groups, related to other professionals such as caseworkers, psychiatrists, and group home staff. Some of the young adults did not feel a sense of privacy, but more so a lack of trust with their service providers. In a systemic review of studies regarding barriers to help-seeking for adolescents and young adults, half of 12 studies cited issues of confidentiality and trust impacting decisions to seek professional help (Gulliver, Griffiths, & Christensen, 2010).

Youth in foster care likely have difficulty trusting people, due to early experiences of abuse, neglect, and/or separation from families. Staff turnover and

switching from pediatric to adult providers negatively reinforces this change and starting over with someone new. Young adults in this study reported situations in which they did not want to have to tell their story again to a new provider or to be pushed to discuss situations which made them uncomfortable with an acquaintance. Adolescent and young adults are more likely to seek help from people with whom they have established relationships and are a trusted source of support, which is often why informal sources are sought out (Osterling & Hines, 2006; Rickwood et al., 2005). Other situations participants reported as challenging were related to feeling judged by their mental health diagnosis and involvement in both the child welfare and mental health systems. They also reported receiving stricter consequences than their peers because of their mental health issues. It was clear that some participants stopped mental health services entirely because they no longer wanted to be associated with the child welfare or mental health systems, which goes beyond previous literature simply depicting self-efficacious reasons for discontinuation.

Lack of voice/choice

Former foster youth in this study consistently referenced situations where they felt that had little voice or choice in decisions that made regarding mental health services, before and after turning 18. In fact, this was the most commonly reported theme in the first phase of the project, and "Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you," also came up as the most difficult situation in the second phase. Literature has consistently pointed to the need for consulting youth in decision-making, as opposed to the more common occurrence of decisions being made without

their knowledge (Scannapieco et al., 2007). This is especially important for youth aging out of care, as they will be expected to make independent decisions after turning 18. In this study, having someone make decisions about their services while in care also impacted young adults feeling as though they did not know how to advocate for themselves when on their own.

Involving youth in decision-making processes while still in foster care, allows them the opportunity for interdependence and to make mistakes with support still in place. In both challenging and supportive situations, participants described the importance of self-efficacy and the need to have a voice in decisions that impacted their future. Fostering resilience in youth through meaningful participation provides youth a sense of control and connectedness in their lives (Ungar & Teram, 2000). Youth in the study who felt they had some impact referenced situations such as "You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18."

Previous literature has identified the need for developmentally appropriate services to adequately address the mental health needs of youth transitioning to adulthood, incorporating more contextual factors in assessing and delivering services (Jensen & Mrazek, 2006). This includes attention to choice and incorporating voice of young adults in services. Participants in the current study describe the need for individualized, developmentally-appropriate services. Many young adults in this study described the belief that youth are prescribed the same services when they come into care; they received counseling and medications "because that's what all youth receive."

Young adults who chose to re-engage in services after 18, reported choosing to do so because services were on their own terms and they could decide what was a good fit for them. Fostering self-efficacy is an important component of providing choice and honoring the voice of youth aging out of foster care. Several of the situations related to self-efficacy stressed the importance of being able to learn and decide what was best for their own mental health. Situations described in this study spanned both choosing to continue mental health services and choosing to discontinue, providing rationale for both that included being able to determine what they felt was the best course of action. Allowing young adults choice and varying levels of support is developmentally appropriate and recognizes that service provision is not the only method of maintaining mental health.

Accessing services

When participants decided to continue or return to mental health services after a period of time, they often described systemic barriers to accessing services after 18. Previous studies have cited reasons for discontinuing services after 18, related to cost or not knowing where to get a prescription filled (McMillen & Raghavan, 2009) or lack of transportation and insurance (Courtney et al., 2011). However, such studies provide little specificity to situations former foster youth encounter in making decisions to discontinue or alternatively return to services, which this study attempts to address. For example, participants in this study pointed out they were unable to continue participating in services due to barriers such as inconsistent transportation and moving to different areas of the metropolitan area or state. More specifically, their bus passes expired or they did not have a friend to ask for a ride.

They also cited the length of time needed to use public transportation when they moved to other areas of the metro or state, which outweighed the benefit of services for them due to loss of pay for hours at work or additional day care that would be needed. Participants also made the decision not to participate in services because they were working several jobs to make ends meet and did not have flexibility in scheduling or were not able to afford the mental health services. The situations described in this study suggest that young adults who want to engage in services are having to weigh the benefit of their participation with immediate circumstance such as the time involved in public transportation or hours they could be paid for working.

Consistent with previous literature (Davis & Sondheimer, 2005; Kruszka et al., 2012), many participants in this study also reported difficulty maintaining insurance after turning 18, either not knowing they needed to change addresses each time they moved or not knowing how to re-enroll if they were discontinued. Youth also reported ease of transition when they had a professional walk them through the process or when services automatically transferred. Hearing from the youth themselves about the difficulties they have encountered trying to get services transferred or re-enroll in services, or alternatively hearing examples of smooth coordination of services seems to reinforce the need for better system coordination.

Accessing services that adequately address the trauma these young adults have experienced as a result of maltreatment, separation, and loss can be difficult or inconsistent. Traumatic stress impacts daily functioning for many young adults, yet service systems vary in their approach to screening for and addressing trauma (Ko et al., 2008). Participants in the study reported not wanting to switch mental health providers

because they did not want to tell their story again. They also provided that it was difficult to ask for help for fear they "will just be put back on medications." The fundamental reason these young adults were brought into services was as a result of the trauma they experienced. A medication-first or medication-only approach, for example, fails to address the underlying trauma. Even if some agencies and practitioners are implementing a trauma-informed approach, there needs to be consistency in which young adults do not fear the response or having to start over with a new provider.

Ongoing social support

Social support is clearly identified in the literature as important in many aspects of development and in the transition to adulthood for foster youth (e.g. Avery, 2010; Goodkind et al., 2011; Samuels & Pryce, 2008). Young adults in this study referred to social support as well as responsive engagement, related to the consistency that occurs in ongoing relationships. For example, young adults identified the importance of maintaining relationships with service providers as helpful. They also described the difficulty in changing providers due to turnover or due to transition to an adult provider, in addition to how these challenges influenced decisions to discontinue services. Although research has cited poor transitions from pediatric to adult mental health service providers resulting in discontinuity in services and disengagement (Davis & Sondheimer, 2005; Singh, 2009), the current research details the importance of the relationship with service providers impacting continued service use.

Participants described being surrounded by people while in care but feeling very isolated after turning 18. Often youth in foster care are supported by several professionals while engaged in services, but after turning 18 many of those services and

supports stop. Participants described feeling as though no one was there for them or they did not have anyone to turn to when they needed help after aging out. Previous research has consistently identified the importance of developing informal mentors and social support that continue beyond system involvement, as a protective factor for youth across a variety of risk conditions (e.g. Greeson & Bowen, 2008; Collins et al., 2010). Other research finds that living without family or strong social supports during mental health treatment predicted disengagement from mental health services for adolescents (Schimmelmann, Conus, Schacht, McGorry & Lambert, 2006).

Regardless if young adults choose to continue formal service involvement, participants in this study reiterated the appreciation for relationships that developed and continued as a result of service-involvement. Maintaining contact with group home staff or foster parents was useful because young adults felt they had someone who still cared and who they could turn to for advice. Although such situations were rated as the most helpful to former foster youth, only 42-46% of participants reported experiencing these situations at least once a month and only 10-14% daily. Considerable research has suggested that significant adult relationships that continue after aging out are associated with more successful outcomes (Collins et al., 2010; Greeson & Bowen, 2008); however only about a third of youth leaving foster care report having a long-term significant relationship or mentor (Munson & McMillen, 2009).

The frequency of contact with mentors and availability for assistance is clearly important, but the findings of this study go a step further to assert that the level of engagement and responsiveness of mentors and supports is paramount. Several situations came up in both phases of research, indicating the helpfulness of mentors or professionals

who helped prepare them for tasks by walking them through the process and/or helping them prepare for meetings. Responding to the individual's needs and actively engaging them in the relationship built trust and confidence in the foster youth's belief they could accomplish tasks independently. This developmentally appropriate informal social support and ongoing mentorship may also meet a mental health need for young adults, which lessens their need for formal services. This builds on previous research which depicts seeking help through informal sources as common and developmentally appropriate for older adolescents (Timlin-Scalera et al., 2003). Successful youth development and transitions to adulthood are linked to supportive relationships that influence developmental trajectories and life changes in adulthood (Arnett & Tanner, 2006). Social support is so important during the transition to adulthood, not only for meeting an immediate need, but also in the ability to develop a social network and capital that can impact multiple areas of functioning. Building a network of relationships can enhance an individual's value and enable them to achieve goals they otherwise could not have achieved (Coleman, 1988). The ecological impacts of building a network of relationships can support mental health and access to services and additional supports if needed, as well as other areas of functioning such as securing employment, housing, etc. which can also impact mental health.

Shared experience/identity

Participants in this study described both challenging and helpful situations associated with their identification as a foster youth. Former foster youth provided supportive situations in which connecting with other foster youth was helpful, especially when there were opportunities for mentorship and leadership. A review of the literature

regarding youth empowerment describe a paucity of research specific to foster youth, typically only in reference to mentoring or education programs (Kaplan, Skolnik, & Turnbull, 2009). Bonding with other youth provided some young adults perspective with their own mental health and leadership opportunities seemed to provide a sense of purpose, that they could help support other youth with similar experiences. Participants depicted situations in which they appreciated shared experience with other foster youth while in care, but also wanted to move beyond this as a social support to learn more skills to help them after leaving care. Previous literature has also emphasized the importance of normalizing experience for foster youth, with more attention to experiences typically associated with adolescence and emerging adulthood, rather than focusing on those associated with being in foster care (Geenen & Powers, 2007). Considering their identity in multiple contexts is important to provide developmentally appropriate services.

Young adults also struggled with their identity related to being a system-involved youth and the stigma that went along with it. In some cases, participants did not want to be associated with the foster care system, which impacted their decision to continue mental health services. Previous research has demonstrated that stigma negatively impacts decisions to seek help (Timlin-Scalera et al., 2003), but this study provides additional information that many dual-system-involved youth are struggling with stigma from multiple domains. This speaks to how interwoven the identity of being involved with mental health services is for many youth involved with the foster care system, as well as the desire for separation and independence from both. Samuels and Pryce (2008) indicate that former foster youth often feel like they have been independent from an early age, due to experiences related to neglect and/or separation from families. Foster care

does not often allow the same independence they may have experienced before care, so it is not surprising that many young adults want to move beyond the identification and dependence of system involvement after turning 18.

Further complicating their separation in identification with the system, many participants describe that the only other young adults they know to live with after turning 18, are those also aging out of foster care, who are often struggling to meet their own mental health needs. Young adults communicate that shared experience can be helpful, but their involvement in the system has limited building relationships with people other than foster youth, which limits their social capital moving forward. Theories of emerging adulthood (Arnett & Tanner, 2006) depict the importance of identity exploration and navigation of social relationships, which are arguably different for vulnerable population such as youth aging out of foster care. By having such a short period of time of identity exploration, foster youth are taking on adult roles often before they acquire the skills, experiences, and relationships that increase the likelihood of success.

Instrument development

This research also contributes to the field by creating an instrument that can be tested with another population. Previous research has been conducted with youth aging out by interviews and focus groups, yet nothing has been done to create an instrument to evaluate challenges and supports this population encounters. The purpose of the behavior analytic model is "to match the person's competencies with the situational demands of the environment by establishing balance in the system either through the promotion of competencies needed to meet the demands, or through decreasing or eliminating the environmental demands" (LeCroy & Whitaker, 2005, p. 1005). The utility of an

inventory to assess an individual's match with situational demands is dependent on the inventory development process, including attention to how well the sample reflects the population, as well as how well the items reflect the problems and supports encountered by the population. This study takes a solid step in that direction through a two-phase process.

Participants in both phases of this project were generally excited to participate, as evidenced by questions of what impact the results might have and communication of satisfaction that their opinions could make a difference in services provided to other foster youth in transition. Validating the need for the research, several young adults in the second phase of the project responded verbally to survey situations that were consistent with their experiences, even if they had not participated in the first phase of the project. The survey was expected to take most young adults 15-30 minutes to complete (from pilot testing), but many respondents took 45-60 minutes and a few took more than 90 minutes to fill out the survey because they wanted to verbally share a story about situations that were similar or slightly varied from their experiences. This was obviously not the case for all participants or for all situations, nor was this tracked except in the researcher's audit trail, but the engagement and commitment to participation in this project from many participants was evident in their desire to share their experience and expand upon the provided situations, which is noteworthy.

Limitations

Although this research offers important implications for policy and practice, which will be discussed in the following section, there are limitations to acknowledge in the current study which caution interpretation. Results of this study are obviously not

generalizable. The focus groups and survey were somewhat retrospective, asking young adults to recall their experiences as they turned 18. Social desirability may have been an issue with young adults reporting what they think the researcher or their peers may want to hear. The group environment may have also influenced responses as group dynamics vary and can elicit more social desirability, especially from an age group that is still socially influenced by peers. Asking about both challenging and supportive situations may have mitigated this a bit, as young adults were not asked to focus solely on problems

Sample. The sample of former foster youth in this study was similar demographically to the population of young adults aging out of care in Arizona, and in many ways similar to samples of former foster youth in other studies; however, the sample is biased by availability of an often difficult to reach population. Those former foster youth most readily available were those currently participating in foster care and/or behavioral health services. Strategies used in larger-scale projects for locating young adults including using child welfare case files, professional search firms, and mail and telephone tracking (Williams, McWilliams, Mainieri, Pecora, & La Belle, 2006). As a dissertation research, this project did not have the financial or personnel resources to conduct such detailed location of former foster youth, however, significant efforts were used to track down as diverse a sample as possible.

Inventory development. A number of elements were considered in development of the inventory items, including several consensus decisions made by the researcher and dissertation committee members, as previously mentioned in the Chapter 3. Although justified in each case, it is recognized that the decisions made may have impacted the overall results and outcome of the study. Although a seemingly comprehensive list of

situations was developed, it was not likely exhaustive. It appeared that saturation had been reached with six focus groups in this project, however it is possible that situations elicited mentioned by only one participant may have been mentioned more if additional participants were included. The inventory was also not intended to be exhaustive, but rather to assess problematic and supportive situations with obvious mental health components and consequences. Limiting the inquiry in this manner was difficult in both phases as many participant associated being involved with mental health services as part of their involvement with the foster care system and often spoke generally about aging out.

The complexity of situations was also a consideration in terms of specificity but also overall length of the situation. Although more detailed situations could more accurately reflect the circumstances the young adults experienced, situations that are too specific may not have resonated with a variety of individuals. Survey research methods also discourage using multidimensional survey items (e.g. Fowler, 2009), which can confuse participants. Some participants may have related to part of the situation but not all components, although difficult to describing situations in detail. Attention was given to avoid this as much as possible in the initial survey item development, but the additional detail needed in some situations may not have resonated with all participants.

Measurement issues. There were also concerns with regard to the inventory itself. Inclusion criteria for the study was that former foster youth must have been involved in mental health services prior to turning 18. There were no exclusions as to the type of mental health service received, and questions were randomly ordered so there was no differentiation between questions regarding different services. Upon administration of

the survey, it became clear that not differentiating the items presented an issue. With regard to the intensity measure of the inventory, there was also not a 'not applicable' option available. All participants received all questions, regardless of which mental health services they had participated in, so marking 'never' as the lowest intensity was the only realistic option for those who did not participate in a particular service referenced.

'Never' also categorically demonstrates a different aspect that 'not applicable.' Not having this designation likely lowered the overall mean scores of both problematic and supportive situations, with no differentiation for those who had never experienced a situation because they had never been exposed to it. This could be an error in not reporting their services accurately, or more likely, responding to questions as part of the overall survey. A couple of participants actually told the researcher they had personally never taken psychiatric medications but knew of other foster youth who had and asked if they could respond based on their perception of their friends' experiences. They were told not to do so, but it is possible other participants responded to these items from the same perspective.

Reading level was also a limitation for some young adults who struggled with the amount of reading involved in the survey and a couple young adults articulated this was why they were choosing not to participate. Others were assisted by staff or the researcher in reading situations, and some asked for clarification of words, especially if English was not their first language. Assistance from adults did not include additional examples of the situation or prompting, other than "have you ever experienced this situation," which was an initial prompt on the survey.

Implications for Social Work

The results of this study provide insight into the complexity of experiences for foster youth transitioning to adulthood with mental health services. Understanding their perspectives as they turn 18 and transition to adult mental health systems or choose to disengage from services altogether provides a unique opportunity to understand their decision-making process. Identifying the most challenging and supportive situations these young adults encounter as they transition provides targetable strategies to improve current policies and programs focused on intervention and prevention for this vulnerable population.

Youth aging out of foster care face many challenges and risks as they transition to adulthood, including issues of mental health. Despite these challenges, some foster youth do successfully transition out of foster care to young adulthood. Independent decisions related to their mental health needs and service utilization likely play a role in outcomes related to many aspects of their lives, such as education, employment, and social relationships. Understanding the needs of foster youth from their own perspective provides insight into the experiences of the stakeholders themselves. Understanding what supports and barriers exist, both formally and informally, can be helpful in developing policies and programs that effectively meet the needs of this vulnerable population. Few studies in this area have detailed specific situations youth experience during the transition from both child welfare and mental health systems and those that have do not provide the depth this study elicits.

Understanding the interaction of ecological issues impacting transitions to adulthood is important when considering the needs and challenges impacting the mental

health of these young adults and should be considered in policies and programs supporting foster youth. Adapting current approaches to recognize the multifaceted interactions and matches between the individual and their environment provides insight and improve outcomes. The behavior analytic model and this research serve as a starting point for understanding how environmental influences interact and impact decision-making related to mental health services during the transition to adulthood.

Practice

Many service providers are aligned with the need to incorporate youth perspectives in policy and practice protocols, which this research can help support. Acknowledging the voices of an often-overlooked population provides insight into the challenges and successes of these young adults. Previous research have used interviews and focus groups to solicit perspectives of youth aging out of foster care, but the questions remains as to what substantial changes have been made as a result. This research provides insight into the decision-making process for this population and provides specific, targetable strategies for intervention and prevention.

A conceptual framework for addressing the mental health needs of foster youth aging out of the child welfare system should focus on engaging youth and examining how contextual factors and support affect their overall well-being as suggested by developmental ecological theory (Belsky, 1993). Reflecting on the individual, family, environment, and interacting influences will help with assessment and individualized treatment and case plans. Treatment should also create an awareness to address the trauma these young adults have experienced, in an effort to provide more responsive services as well as provide an opportunity for the young adults to rebuild a sense of

control (Hopper et al., 2010). Considering multidimensional, contextual needs allows for more complete and helpful integration of services to adequately meet the mental health needs of youth (Anderson & Mohr, 2003). Considering their history and future orientations allow practitioners the ability to help them in the present.

There is also a need for integrated transition planning and increased communication amongst treatment team members as the youth nears transition age, and beyond if applicable. Better communication and coordination between systems and team members is needed so that young adults know where to seek help if they choose to do so. Former foster youth in this study were specific about mixed messages and difficulty trusting professionals, because they either changed frequently or provided different direction based on which treatment plan they were responsible for. Previous research has suggested young adults prefer to seek help from informal sources such as friends and parents, rather than professionals (Del Mauro & Williams, 2012; Sheffield et al., 2004), which is logical considering the mistrust that exists for many system-involved youth and young adults. Consistency and communication can establish trust and increase feelings of self-efficacy.

Ensuring team members are consistently providing developmentally appropriate services is also important, considering the development of maturity and responsibility that continues into early adulthood. Young adults can still be easily swayed by emotions, more strongly activated when issues of security and survival are threatened (Arnett & Tanner, 2006). Services need to consider the behavioral, psychological, and social needs of the individual and how interactions with multiple service systems impact development and mental health needs. Professionals who trusted the ability of young adults to make

decisions, who were also supportive in helping young adults accomplish tasks for the first time, were highly valued by participants in this study.

Many current programs of independent living skills focus on tangible skills such as how to balance a checkbook or fill out a job application. Although these skills can be useful after turning 18, problem-solving should be a stronger priority in independent living training and programs. The challenging situations described by participants in this study reflect not knowing how to access services or resources available as well as feeling overwhelmed with responsibilities and uncertainty of individual priorities. Considering the often lack of supportive relationships during the transition to adulthood, problem-solving skills are essential. Training in problem-solving while in care allows youth to make mistakes while still being supported, and sets them up to successfully manage challenging situations after leaving care.

Findings support the need for a period of interdependence, as foster youth often lack the traditional financial and emotional supports which impact not only their mental health but other areas of functioning characteristic of independent living and adulthood, which is consistent with research on emerging adulthood (Arnett & Tanner, 2006). Professionals and mentors should help young adults learn to recognize and seek help when needed, whether that be from formal or informal supports. Young adults in this study felt supported when people helped them learn how to advocate for themselves, including preparation for meetings so they felt confident in communicating their needs.

Allowing foster youth a real voice in decisions that affect them, gives them buy-in as well as practice in decision-making. Allowing youth a voice promotes realistic transition planning and avoids feelings of coercion expressed by many participants in the

study. For example, if a youth wants to discontinue taking psychiatric medication, they will do so when they age out so it is best to make realistic plans to discontinue gradually under medical supervision, while still in care. Threatening to take away privileges or ignoring their request does not change their mind. Rather, respecting their self-determination allows them to develop a sense of ownership over decisions and empowers them to advocate for themselves in a mature manner. It also provides support during the transition and continued access to services if needed.

Realistic transition planning should include attention to ongoing support and permanency for this population as well. Rather than assuming youth will be completely independent upon turning 18, practitioners should focus on building relationships and connections can that can serve as support systems more permanently for youth aging out of care (Avery, 2010). Consistent with previous research, this study provided that some young adults continued or regained contact with biological family members, who may have been considered ineligible or inappropriate placements while they were in care (Collins et al., 2010). Understanding how these contextual supports may provide needed emotional connection and support is important in promoting positive outcomes.

Practitioners should also help adolescents and young adults in foster care with identity development beyond foster care. Identity must be understood in multiple contexts including societal, personal, and familial expectations (Samuels & Pryce, 2008). The stigma of involvement in both mental health and child welfare systems can negatively impact young adults' self-esteem and prevent development of healthy relationships both in and beyond their system involvement. Developing a sense of identity and relationships outside of care promotes expansion of their social support

capital and future resources. It may also help prevent feelings of isolation after leaving care and professionals who may have provided significant support during their time in care. Connecting young adults to natural mentors can provide the ongoing support that extends beyond care, and promotes feelings of hope for the future (e.g. Greeson & Bowen, 2008).

Collaborative efforts across a broad range of formal and informal systems can have a dramatic impact on the mental health of youth transitioning to adulthood. Mental health and development are complex and evolving processes that require supportive communities and access to quality services. Creating environments that promote and support mental health, empowerment, and resiliency can improve outcomes for this vulnerable population.

Policy

Child welfare policies and practices have been changing to allow more youth to remain in care beyond age 18; yet the majority of youth do not remain in care and 60% of the youth who were participating in mental health services stop within a month of leaving care (McMillen & Raghavan, 2009). Clearly there are policies in place to support youth aging out with mental health needs, however there remains a disconnect between policies in place and outcomes for youth aging out of foster care. Seemingly simple considerations such as providing and including young adults in collaborative transition planning, and service provision that includes attention to logistical needs such as transportation, scheduling, and other financial barriers may positively impact their participation in services.

The behavioral health and child welfare systems both have a history of fragmentation, which affects the continuity of care and system cooperation within and between systems. This seems to be an issue while youth are still in care, with lack of consistent client planning and communication of services (McMillen et al., 2007); however, it continues more prominently as youth transition from pediatric to adult systems. Continuity of services can be difficult with separate divisions of pediatric and adult mental health systems, with different criteria used to determine eligibility for services and lack of shared case planning or management (Davis & Sondheimer, 2005). Identifying specific areas of policy implementation such as denial of coverage or having a designated person to help them navigate the enrollment process may strengthen relationships between systems or offer areas for improvement.

Although these suggested practices seem to address contextual needs for foster youth and their mental health, limitations as to policy implementation and quality of care currently exist. It is difficult to identify key recommendations without considering contextual factors, however the breadth of interacting systems is great as is the self-determination of youth to determine whether services are needed to meet their mental health needs. Recent healthcare legislation increased insurance eligibility for foster youth from age 21 to 26 (AZDES, 2012), however, there may be a gap of youth who between 22 and 26 who are unaware of their continued eligibility. Following up with these former foster care youth provides an opportunity to provide a service but also an opportunity for contact with someone knowledgeable about services. Policies and programs should focus on the accessibility of services so that young adults can make informed decisions based

on their individual circumstances. This research supports the need for consistency in expectations and implementation of policies.

Education

The foundation of social work education is based on human behavior and the social environment. This research provides examples of the importance of multidimensional assessment and key concepts related to adolescent development and emerging adulthood for vulnerable populations. Training practitioners to consider contextual evidence and multidisciplinary system interactions is relevant working with this population but also with most any population. The opportunity to explore specific challenges and supports impacting this population transitioning to adulthood provides real-world application, which engages students and requires them to think critically about issues of social and economic justice.

Considering the impact of trauma and mental health on transitions and future parenting provides examples across the lifespan. Practitioners should be taught the importance of trauma-informed care and how to use this framework to understand and effectively respond to the individual needs of young adults. Young adults with a history of maltreatment are likely to come in contact with multiple service systems in which social workers may be employed. Understanding how trauma impacts behavior and response to stress is important. This research provides evidence for direct practice with this population, as well as illustrates macro implications at systems levels. Understanding the impact and interaction of contextual and historical influences is important to improve service-delivery strategies. Application of theory to practice as well as translating research to policy and practice are all relevant to social work education

and demonstrated in this research.

Beyond local impact, implications from this research can contribute to the literature regarding how to best support the well-being of transitioning foster youth and contribute to positive outcomes in future generations by prevent the intergenerational transmission of child abuse and neglect. Improving services and systems of care for youth aging out of foster care impacts the next generation and likely contributes to preventing future system involvement on many levels, including child welfare system involvement. Recognizing the ways in which individuals are able to meet their mental health needs through both formal and informal sources is important and social work practitioners should focus on more education, skill-building, and building on existing relationships to meet the varying self-identified needs of youth transitioning to adulthood from systems of care.

Future Directions

This two-phase project was designed to provide information for development of programs and services which can increase success of young adults aging out of foster care with mental health needs. The full behavior analytic model is composed of additional steps of response enumeration, response evaluation, instrument development, and instrument evaluation (Goldfried & D'Zurilla, 1969). The inventory was constructed to rate the frequency and intensity of the situations former foster youth experienced. As such, it can be used in future research to elicit strategies of response to the most prominent challenging and supportive situations, have them evaluated by professionals familiar with the population, and eventually create a codebook/manual for the purpose of clinical assessment. The current inventory of situational analysis provides the basis for

these continued steps, while also providing utility in targetable strategies for current program and policy development.

The EFA that was conducted with this inventory also sets up conducting a confirmatory factor analysis with another sample of the population to further examine the structural analysis of the situations, as well as to confirm the factors identified adequately measure and reflect the challenges and successes of youth aging out of systems of care. Determining the nature of variables which account for the variation and covariation among the observed measures allows deeper understanding of the experiences and determination of the most pressing concerns to be addressed. Ultimately, this information informs programs of interventions and addresses specific mental health service concerns of youth aging out of the foster care system.

Future research should also examine more specifically the population of former foster youth who are not currently engaged in services. An attempt was also made to gather data from former foster youth in other states, as a result of the increased accessibility of an online version of the study. The subset of young adults from other states was small, and as previously noted varied substantially enough in key demographic characteristics that is was excluded from analysis. It would be of interest to sample a larger proportion of young adults in other states for comparison and broader examination of situations.

The research area of youth aging out of foster care, concurrently involved with mental health services is complex and requires developmental ecological considerations. This dissertation provides an exploratory analysis of the complexity of both challenging and supportive experiences as a solid step in the direction of improving outcomes for

youth aging out. The findings provide targetable strategies for improvements in service provision but also highlight the need to strengthen and promote self-determination and accessibility to the resources for young adults to meet their self-identified mental health needs through both informal and formal sources. Attention to trauma and responsive engagement at this level may promote the well-being of this population and prevent child abuse and neglect in future generations.

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APPENDIX A

DEMOGRAPHIC SURVEY FOR RECRUITMENT

I am a graduate student researcher within the School of Social Work at Arizona State University. I am conducting a research study to understand more about the experiences of mental health services for youth aging out of foster care.

I am inviting your participation, which will involve taking an online survey of some basic demographic information, which takes approximately 5 to 10 minutes. If you feel uncomfortable with any question, you are free to skip it, and you can stop participation at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. There are no foreseeable risks or discomforts to your participation. We hope you will consider participating because your feedback could be helpful as we seek to understand more about what challenges and benefits youth aging out experience related to mental health services. If you know of other young adults who have aged out who might be interested in participating in this study, please feel free to forward them the email inviting their participation in this study.

Your responses will be anonymous unless you provide your contact information to show your willingness to participate in a follow-up focus group, describing your experiences with mental health services before and after aging out of foster care, which will take 1.5 to 2 hours. Then, I will link your survey data with your focus group data. However, your responses will remain strictly confidential. The data will be stored on a password protected computer at ASU.

Only the researchers involved in this project will be allowed access to the data and the contact information. The results of this study may be used in reports, presentations, or publications but your name will not be used. If you have any questions concerning the research study, please contact me at mhayes3@asu.edu or at (480) 381-9809. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Your participation in the survey will be considered your consent to participate.

Megan Hayes, MSW
Arizona State University School of Social Work

What is your current age?
18 19 20 21 Other (please specify)

Did you turn 18 while in the foster care system?
Yes
No (please specify)

Did you live in a foster care (ie. group home, treatment center, foster) placement at least one year before turning 18?
Yes No

How long were you involved with the foster care system, all together? Please enter months and years (ie. 4 years, 2 months). Even if it was broken up over several years, add the time up collectively.

____

Were you involved with mental health services (ie. case management, counseling, anger management (or other) groups, psychiatric crisis services/hospitalization, psychiatric medications) at any point while in the foster care system?
Yes No

How do you identify your race/ethnicity? (Please choose one).
African American
American Indian
Asian
White/Caucasian
Latino/a or Hispanic
Multiracial
Other (please specify)

Which mental health services were you involved in and how long did you participate before turning 18? (Even if it was broken up over several years, add the time up collectively.) Please enter months and years (ie. 4 years, 2 months).
Individual counseling
Anger management group
Self-esteem building group
Art therapy
Equine therapy
Family counseling
Psychiatric counseling

Psychiatric medication
Crisis services
Inpatient hospitalization
Residential treatment
Other (please specify)
Other (please specify)

What is your gender?
Male
Female
Transgender

What is your highest level of education? (Please choose one)
Less than 8th grade
Completed some high school
High school diploma
GED
Some college - no degree
Associate's degree
Bachelor's degree
Other

Are you employed?
Yes, full-time
Yes, part-time
No, I'm not currently employed

What is your current household annual income, not including disability income?
Less than $5000
$5,000-$10,000
$10,000-$19,999
$20,000-$29,999
$30,000-$39,999
$40,000-$49,999
$50,000-$59,999
$60,000-$69,999
$70,000 or more

Do you receive disability income?
Yes No

Where do you currently live?
With biological family members
With extended family members
With foster family
With friends
In a group home
In a shelter
In my own apartment/home
I do not currently have a consistent home
Other (please specify)

We are looking for the young adults to participate in a focus group of their peers to help us learn more about the experiences with mental health services for youth aging out of foster care. The focus groups will take place at the MyLife Festival on March 23rd, and will last 1.5 to 2 hours in length. Each participant will be given a $25 giftcard to honor their time in participation. What we learn from these focus groups will help inform training, programs, and policies related to what youth aging out find helpful or challenging related to mental health services and aging out.

Are you willing to be considered for these focus groups? If so, please provide contact information including a first name, phone number and/or email address where we can contact you. Thanks for considering this request!

APPENDIX B

INFORMATION LETTER: FOCUS GROUPS

Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care

Dear Participant:

I am a researcher within the School of Social Work at Arizona State University. I am conducting a study to understand the experiences and needs of former foster care youth in Arizona. I am inviting your participation, which will involve participating in a focus group, describing your experience of mental health services before and after turning 18 in the foster care system.

In order to participate, you must be at least 18 years of age, have received mental health services and resided in a foster care setting at least one year prior to turning 18. The focus groups will range from 90 to 120 minutes and will be conducted at an a local agency/community setting. I am also providing a $25 giftcard as an acknowledgement of your time.

Your participation in this study is voluntary. If you choose not to participate, to not answer any question, or to withdraw from the study at any time, there is no penalty. Your responses will in no way jeopardize your standing with ______________________ (agency) or Arizona State University. If you choose to participate, you have the opportunity to contribute to our knowledge base regarding perceptions and experiences of young adults who have aged out of foster care. There are no foreseeable risks or discomforts involved in your participation.

Information obtained in this study is strictly confidential. The results of this research study may be used in reports, presentations, and publications, but the researchers will not identify you. I would like to audiotape the focus group. You will not be recorded, unless you give permission. If you give permission to be taped, you have the right to ask for the recording to be stopped at any time.

Due to the nature of group participation in focus groups, the researchers cannot guarantee complete confidentiality of your data from this part of the study. It may be possible that others will know what you have reported although efforts will be made by the researcher to express the importance of confidentiality in the group and to de-identify information following the group. In order to maintain confidentiality of your records, investigators will transcribe the focus group, removing any potentially identifying information and disposing of audio recordings.

If you have any questions concerning the research study, please contact Cindy Lietz (602-496-0091, clietz@asu.edu). If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Sincerely,
Megan Hayes, MSW
Cynthia Lietz, PhD

By signing below you are agreeing to participate to in the study.

__________________________ __________________________
Signature Date

By signing below, you are agreeing to be taped.

____

APPENDIX C

INFORMATION LETTER: INTERVIEWS

Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care

Dear Participant:
I am a researcher within the School of Social Work at Arizona State University. I am conducting a study to understand the experiences and needs of former foster care youth in Arizona. As a community member who is familiar with this population I am inviting your participation, which will involve participating in an interview describing your perceptions of mental health services for young adults before and after turning 18 in the foster care system.

In order to participate, you must be at least 18 years of age and familiar with mental health services for foster youth aging out of care. The interviews will range from 30 to 60 minutes and can be conducted at a place of your choice, either your agency/home, ASU, or another location you prefer. I am also providing a $25 giftcard as an acknowledgement of your time.

Your participation in this study is voluntary. If you choose not to participate, to not answer any question, or to withdraw from the study at any time, there is no penalty. Your responses will in no way jeopardize your standing with ______________________ (agency) or Arizona State University. If you choose to participate, you have the opportunity to contribute to our knowledge base regarding perceptions and experiences of young adults who have aged out of foster care. There are no foreseeable risks or discomforts involved in your participation.

Information obtained in this study is strictly confidential. The results of this research study may be used in reports, presentations, and publications, but the researchers will not identify you. I would like to audiotape the interview. You will not be recorded, unless you give permission. If you give permission to be taped, you have the right to ask for the recording to be stopped at any time.

Interviews will be conducted individually with the participant and the researcher, so confidentiality will be maintained by the researcher. In order to maintain confidentiality of your records, investigators will transcribe the interview, removing any potentially identifying information and disposing of audio recordings.

If you have any questions concerning the research study, please contact Cindy Lietz (602-496-0091, clietz@asu.edu). If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Sincerely,

Megan Hayes, MSW
Cynthia Lietz, PhD

Please let me know if you wish to participate.

APPENDIX D

INTERVIEW GUIDE: FOCUS GROUPS

Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care

Thank you for agreeing to participate in this focus group to share your experiences with mental health services and aging out of foster care. Your experiences may be similar or different than your peers, but equally important in helping to understand your perspectives.

It is important that all participants remember the sensitivity of the information that may be disclosed as part of the focus group. What is said in the focus group should remain in this room, out of respect for your peers and yourself. With that said, it is important to know that I cannot guarantee other members of this focus group will not disclose information shared here outside of the group, so please be mindful of this. With everyone's permission, I will be audio-recording the focus group to make sure I capture your experiences as you describe them. When I write up the notes from the audio recording, I will remove any potentially identifying information like names or agencies, and then dispose of the audio recordings entirely in order to ensure your anonymity. So let's get started.

For the purposes of our conversation today, mental health services include things like individual counseling, group counseling, psychiatric medications, case management or hospitalization due to emotional distress.

1. Let's begin by talking a little bit about how you become involved with mental health services. Think back to the first time you received a psychiatric evaluation or spoke to a counselor, for example.
    a. What was your experience with mental health services while in foster care? What situations were helpful or not helpful?
2. Now I want you to think about when you turned 18 and aged out or transitioned from foster care. Have your experiences of these services changed since turning 18 and aging out of foster care?
    a. (If yes), how have your experiences changed? Can you describe how your experiences changed?
    b. (If no), how have your experiences been the same?
    c. Do you feel your mental health needs are being met since turning 18?
3. So now for my next couple of questions, I'm going to give you some index cards and have you take a few minutes to think about your experiences and write down some situations. You're not turning this in, I just want to help you organize your thoughts. Okay, so think back to the time, right when you were turning 18 and transitioning from the system, a couple months before and couple months after. Now I want you to think about mental health needs during that transition time. I'm going to ask you about difficult situations related to mental health services and transitioning to adulthood and then later I'll ask about supportive situations. Go ahead and make a list of difficult or challenging situations you faced related to meeting your mental health needs, such as situations when you were not sure what to do or situations that did not go well.
   Possible follow-up questions:

a. Now look at your cards, can you provide examples of situations which were difficult during this transition?
b. Can you describe what about these situations were difficult?
c. Did these problems keep you from being able to meet your mental health needs, and if so, in what ways?

4. Okay, now make a list of situations that you found helpful in meeting your mental health needs, like when you felt supported and/or confident in making decisions as you aged out.
   Possible follow-up questions:
   a. Now look at your cards, can you provide examples of situations that were helpful during this transition?
   b. Can you describe what about these situations were helpful?
   c. Did these helpful situations support you in meeting your mental health needs, and if so, in what ways?
5. Do you feel like the situations we've discussed encompass your experiences with mental health services as you've aged out of care? Is there anything else you would add? In looking at your list, is there anything we haven't covered?

APPENDIX E

INTERVIEW GUIDE: AGENCY/COMMUNITY INTERVIEWS

Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care

Thank you for agreeing to participate in this interview to share your experiences working with youth aging out of foster care who may be utilizing mental health services. I have been conducting focus groups with the young adults, asking about their experiences with problematic and supportive situations, but I'd also like to get perspectives from adults who are familiar with the population and issues and supports they may encounter. With your permission, I will be audio-recording the interview to make sure I capture your experiences as you describe them.

When I write up the notes from the audio recording, I will remove any potentially identifying information like names or agencies, and then dispose of the audio recordings entirely in order to ensure your anonymity. So let's get started.

For the purposes of our conversation today, mental health services include things like individual counseling, group counseling, psychiatric medications, case management or hospitalization due to emotional distress.

1. Let's begin by talking about what your role is with youth aging out of foster care. Can you share a bit about your experience with this population?
2. So now for my next couple of questions, I'm going to ask about specific situations youth aging out face, when meeting their mental health needs.
    a. As youth turn 18 and age out of the foster care system, can you describe some of the difficult or challenging situations they may encounter, such as situations in which they may not be sure what to do or situations that do not go well?
    b. Now can you describe situations that you've seen as helpful for young adults to meet their mental health needs, like when they've been supported and/or confident in making decisions as they aged out.
3. Do you feel like the situations we've discussed encompass young adult's experiences with mental health services as they age out of care? Is there anything else you would add?

APPENDIX F

SURVEY/RECRUITMENT LETTER

Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care

Dear Participant,

I am a graduate student researcher within the School of Social Work at Arizona State University (ASU). I am conducting a research study to understand more about the experiences of mental health services for youth aging out of foster care. The purpose of the study is to understand what challenges and supports you may have encountered with mental health services and transitioning to adulthood, and how frequently you have encountered such challenges and supports.

I am inviting your participation, which will involve taking an online survey, which takes approximately 10-20 minutes. If you feel uncomfortable with any question, you are free to skip it, and you can stop participation at any time. In order to participate, you must be 18-22 years of age, have received mental health services and resided in a foster care setting at least one year prior to turning 18.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. Some of the survey questions might seem personal or could be upsetting. Remember, you can stop participating in the survey at any time. If you choose to participate, you can receive $10 cash/giftcard in appreciation of your time, and your feedback could inform mental health and foster care policies and programs aimed to support youth aging out of foster care.

Your responses will be anonymous and the data will be stored on a password protected computer at ASU. Only the researchers involved in this project will be allowed access to the data collected. The results of this study may be used in reports, presentations, or publications but your name will not be used.

We hope you will consider participating because your feedback could be helpful as we seek to understand more about what challenges and benefits youth aging out experience related to mental health services. If you know of other young adults who have aged out who might be interested in participating in this study, please feel free to forward them the email inviting their participation in this study.

If you have any questions concerning the research study, please contact Cindy Lietz (602-496-0091, clietz@asu.edu). If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Sincerely,

Megan Hayes, MSW
Cynthia Lietz, PhD

Your participation in the survey will be considered your consent to participate.

<u>Please circle your responses to the following questions:</u>

What is your current age? **18 19 20 21 22 Other (please specify)_________**

Did you turn 18 while living/placed in a foster care placement (this includes living in a foster home, kinship/relative placement, group home or other residential setting)?

Yes No (please specify): __________

How long were you involved with the foster care system, all together? Please enter months and years (ie. 4 years, 2 months) <u>Even if it was broken up over several years, add the time up collectively</u>. ____________________

Were you involved with mental health services (ie. counseling, anger management (or other) groups, psychiatric crisis services/hospitalization, or medications for emotional or behavioral issues) at any point while in the foster care system? Yes No

In what state do you currently reside? Arizona, USA Other (Please specify) _______

Where do you currently live?

With biological family members	With friends	In my own apartment/home
With foster family	In a shelter	I do not have a consistent home
With extended family members	In a group home	Other (please specify): _________

How do you identify your race/ethnicity? (Please choose one).

African American	American Indian	Asian	White/ Caucasian	Latino/a or Hispanic	Multiracial	Other (please specify)________

What is your gender?

Male Female Transgender

Are you employed?

Yes, full-time Yes, part-time No, I'm not

What is your highest level of education? (Please choose one)

Less than 8th grade	High school diploma	Other (please specify):_________
Still in high school/GED classes	GED	
Completed some high school	Some college - no degree	
	Associate's degree	
	Bachelor's degree	

What mental health services were you involved in <u>BEFORE you turned 18</u>? (Please choose all that apply.)

A community mental health center, child guidance clinic, or outpatient mental health clinic
A professional in a private office like a psychologist, psychiatrist, social worker, or counselor
A healer, Shaman, or spiritualist
Substance abuse treatment program/group
Hospitalization for mental health problems
Medication for emotional or behavioral problem

What mental health services were you involved in AFTER you turned 18? (Please choose all that apply.)

A community mental health center, child guidance clinic, or outpatient mental health clinic
A professional in a private office like a psychologist, psychiatrist, social worker, or counselor
A healer, Shaman, or spiritiualist
Substance abuse treatment program/group
Hospitalization for mental health problems
Medication for emotional or behavioral problems

How satisfied are you that your mental health needs are currently being met?

Very satisfied	Satisfied	Neither Satisfied or Dissatisfied	Dissatisfied	Very Dissatisfied

Please indicate <u>how frequently</u> you have experienced each situation and <u>how DIFFICULT</u> the situation was for you to handle. PLEASE **CIRCLE ONE** NUMBER/LETTER FOR EACH STATEMENT

	Frequency (How often you have experienced each situation)					**Difficulty** (How difficult the situation is for you to handle)			
	Never	1-2 times a year	1-2 times a month	1-2 times a week	1-2 times a day	Not at all	A Little Bit	A Lot	Couldn't Be Worse
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	N	Y	M	W	D	1	2	3	4
After refusing to take your medications while in care, you were told privileges would be taken away if you refused to comply.	N	Y	M	W	D	1	2	3	4
You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	N	Y	M	W	D	1	2	3	4
Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	N	Y	M	W	D	1	2	3	4
You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	N	Y	M	W	D	1	2	3	4
Medications made you feel sick. They made you feel loopy or groggy.	N	Y	M	W	D	1	2	3	4
You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	N	Y	M	W	D	1	2	3	4
Your mental health diagnosis has changed multiple times since you first entered care. You don't feel any different.	N	Y	M	W	D	1	2	3	4
You went to the hospital when your mental health got really bad, but you just ended up with doctor's bills you can't pay.	N	Y	M	W	D	1	2	3	4
Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth	N	Y	M	W	D	1	2	3	4

before getting to know you.									
You felt like your counselor was not really listening when you wanted to talk. They seemed distracted or just took notes.	N	Y	M	W	D	1	2	3	4
Some medications helped calm you down, but they made you sleepy in school so you'd have to take another medication to wake you up.	N	Y	M	W	D	1	2	3	4
Your counselor would play cards or board games and would not really talk about things that were important to you.	N	Y	M	W	D	1	2	3	4
You were prescribed medication to help with one mood but then it caused a different mood and you were prescribed another medication to help with that.	N	Y	M	W	D	1	2	3	4
You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	N	Y	M	W	D	1	2	3	4
Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments.	N	Y	M	W	D	1	2	3	4
You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	N	Y	M	W	D	1	2	3	4
You feel like medications changed your personality.	N	Y	M	W	D	1	2	3	4
At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	N	Y	M	W	D	1	2	3	4
A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	N	Y	M	W	D	1	2	3	4
At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	N	Y	M	W	D	1	2	3	4
You had insurance when you turned 18, but when you went to refill your prescription the pharmacy told you it was no	N	Y	M	W	D	1	2	3	4

longer covered.									
It's hard for you to ask for any services or help because you're afraid you will just be put back on medications.	N	Y	M	W	D	1	2	3	4
You tried to figure out your insurance by calling back and forth between professionals and your insurance, but it became so overwhelming you just gave up.	N	Y	M	W	D	1	2	3	4
You weren't able to continue participating in support groups because you kept moving to different areas to live.	N	Y	M	W	D	1	2	3	4
If you complained about your medications or disagreed with the doctor, you were prescribed more medications or higher doses of ones you were already taking.	N	Y	M	W	D	1	2	3	4
Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	N	Y	M	W	D	1	2	3	4
You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	N	Y	M	W	D	1	2	3	4
When you were first prescribed medications, no one explained why you were taking medications and any potential side effects.	N	Y	M	W	D	1	2	3	4
You were supposed to be switched to a counselor with an adult provider but the paperwork or communication didn't go through so you gave up.	N	Y	M	W	D	1	2	3	4
You thought you had insurance but didn't know you needed to change your address each time you moved in order to remain covered.	N	Y	M	W	D	1	2	3	4
You took too many medications and ended up in the hospital. Mental health providers felt it was a substance abuse issue but substance abuse providers thought it was a suicide attempt. Neither one wanted to help you.	N	Y	M	W	D	1	2	3	4
You had a transitional team composed of several people, but when you needed help you	N	Y	M	W	D	1	2	3	4

weren't sure who to contact.									
When you did contact people for help, you received mixed messages from different people, which left you confused.	N	Y	M	W	D	1	2	3	4
You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	N	Y	M	W	D	1	2	3	4
The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	N	Y	M	W	D	1	2	3	4
You were prescribed medication for something that could be fixed by other methods. You went in to talk to someone about your problems and ended up prescribed medication.	N	Y	M	W	D	1	2	3	4
It felt like people were putting you on medications to control you. You felt that medications were prescribed to make the foster parent or group home staff's job easier.	N	Y	M	W	D	1	2	3	4
You were told you have to take your medications in order to remain in the program or receive other services. You felt you did not have a choice.	N	Y	M	W	D	1	2	3	4
You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	N	Y	M	W	D	1	2	3	4
Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	N	Y	M	W	D	1	2	3	4
You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	N	Y	M	W	D	1	2	3	4
It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	N	Y	M	W	D	1	2	3	4
Professionals may have discussed how to return to services after 18 if you decided you needed help,	N	Y	M	W	D	1	2	3	4

but you didn't remember what they told you to do or who to contact when you actually needed help.									
You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse.	N	Y	M	W	D	1	2	3	4
The doctors thought you were taking your medications, but you were not. They comment on the positive changes they've seen as a result of your medication.	N	Y	M	W	D	1	2	3	4
You didn't continue mental health services after turning 18 because you would lose pay for missing work.	N	Y	M	W	D	1	2	3	4
You were kicked out of where you lived because of symptoms related to your mental health.	N	Y	M	W	D	1	2	3	4
You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	N	Y	M	W	D	1	2	3	4
You are worried about the long-term effects of medications. You have heard of others who have stayed on medications who have serious medical issues as a result.	N	Y	M	W	D	1	2	3	4
You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	N	Y	M	W	D	1	2	3	4
Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	N	Y	M	W	D	1	2	3	4
You have a hard time trusting professionals because they change so frequently.	N	Y	M	W	D	1	2	3	4
Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	N	Y	M	W	D	1	2	3	4

Please indicate <u>how frequently</u> you have experienced each situation and <u>how SUPPORTIVE</u> the situation was for you. PLEASE **CIRCLE ONE** NUMBER/LETTER FOR EACH STATEMENT

	Frequency (How often you have experienced each situation)					**Support** (How helpful was the situation)			
	Never	1-2 times **a year**	1-2 times **a month**	1-2 times **a week**	1-2 times a day	Not at all	A Little Bit	A Lot	Couldn't Be Better
Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	N	Y	M	W	D	1	2	3	4
Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	N	Y	M	W	D	1	2	3	4
You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	N	Y	M	W	D	1	2	3	4
Having leadership opportunities helped you gain perspective with your own mental health.	N	Y	M	W	D	1	2	3	4
You get to bond with other youth/young adults experiencing similar situations at programs, which was helpful.	N	Y	M	W	D	1	2	3	4
You can take care of your own mental health needs, through marijuana, which calms you down.	N	Y	M	W	D	1	2	3	4
Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	N	Y	M	W	D	1	2	3	4
You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	N	Y	M	W	D	1	2	3	4
The medication you're prescribed helps you concentrate and/or manage your moods.	N	Y	M	W	D	1	2	3	4
After 18, you don't have to tell everyone you have a mental health diagnosis. You have a fresh start.	N	Y	M	W	D	1	2	3	4
You were able to get back into services by going to the emergency room or utilizing crisis services.	N	Y	M	W	D	1	2	3	4
Returning to your biological family was helpful because they supported you emotionally. They understood you.	N	Y	M	W	D	1	2	3	4

You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	N	Y	M	W	D	1	2	3	4
An adult from a religious community/church took the time to get to know you and maintained contact with you after 18.	N	Y	M	W	D	1	2	3	4
You were able to meet your own mental health needs through finding resources on your own by looking them up or joining support groups.	N	Y	M	W	D	1	2	3	4
Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed you a chance to make more independent decisions while still being supported.	N	Y	M	W	D	1	2	3	4
Mentors went to court with you even after you turned 18. Just knowing somebody supported you and would make sure you were treated fairly was a relief.	N	Y	M	W	D	1	2	3	4
You have someone to call if things get really tough. You have a person who listens and gives you advice.	N	Y	M	W	D	1	2	3	4
It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	N	Y	M	W	D	1	2	3	4
You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	N	Y	M	W	D	1	2	3	4
You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	N	Y	M	W	D	1	2	3	4
Teachers or coaches at your school provided emotional support and encouraged you.	N	Y	M	W	D	1	2	3	4
You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	N	Y	M	W	D	1	2	3	4
You mentor other youth in similar situations by listening and giving advice when needed, which makes you feel good.	N	Y	M	W	D	1	2	3	4
You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18.	N	Y	M	W	D	1	2	3	4

Your doctor knew you weren't going to continue taking medications after turning 18, so they helped you get off of them gradually.	N	Y	M	W	D	1	2	3	4
Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	N	Y	M	W	D	1	2	3	4
Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	N	Y	M	W	D	1	2	3	4
You were able to return to services after 18, because you still knew another youth in care who helped connect you to people.	N	Y	M	W	D	1	2	3	4
You maintain your mental health by using distractions such as school, work, or other activities.	N	Y	M	W	D	1	2	3	4
A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	N	Y	M	W	D	1	2	3	4
An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks, to walk you through the process.	N	Y	M	W	D	1	2	3	4

Thank you for providing valuable feedback about your experiences with mental health services while aging out of the foster care system. Your input will be used to help understand the difficulties and strategies youth in foster care encounter in trying to meet their mental health needs while transitioning to adulthood.

APPENDIX G

TABLE OF DIFFICULT SITUATIONS MEAN INTENSITIES

Most difficult situations for former foster youth (n =121)

Situation	Mean	SD
You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	2.53	1.03
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	2.46	0.98
You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	2.41	1.08
You have a hard time trusting professionals because they change so frequently.	2.37	1.12
Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	2.37	1.17
When you did contact people for help, you received mixed messages from different people, which left you confused.	2.34	1.14
Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	2.29	1.21
Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	2.28	1.24
Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	2.25	1.17
After refusing to take your medications while in care, you were told privileges would be taken away if you refused to comply.	2.24	1.19
A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	2.23	1.23
You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	2.21	1.09
At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	2.18	1.18
You had a transitional team composed of several people, but when you needed help you weren't sure who to contact.	2.17	1.13
It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	2.15	1.08

Appendix G (continued)

The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	2.15	1.11
Professionals may have discussed how to return to services after 18 if you decided you needed help, but you didn't remember what they told you to do or who to contact when you actually needed help.	2.14	1.17
You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	2.13	1.18
You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	2.12	1.16
Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments.	2.11	1.10
You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	2.11	1.18
It felt like people were putting you on medications to control you. You felt that medications were prescribed to make the foster parent or group home staff's job easier.	2.11	1.19
Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	2.08	1.07
Your mental health diagnosis has changed multiple times since you first entered care. You don't feel any different.	2.05	1.12
You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	2.05	1.15
Medications made you feel sick. They made you feel loopy or groggy.	2.04	1.18
You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	2.02	1.12
You were prescribed medication to help with one mood but then it caused a different mood and you were prescribed another medication to help with that.	2.02	1.13
Some medications helped calm you down, but they made you sleepy in school so you'd have to take another medication to wake you up.	2.01	1.15
You were told you have to take your medications in order to remain in the program or receive other services. You felt you did not have a choice.	2.01	1.20
You feel like medications changed your personality.	2.00	1.10

Appendix G (continued)

You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	2.00	1.10
You thought you had insurance but didn't know you needed to change your address each time you moved in order to remain covered.	1.98	1.11
You had insurance when you turned 18, but when you went to refill your prescription the pharmacy told you it was no longer covered.	1.98	1.14
You were prescribed medication for something that could be fixed by other methods. You went in to talk to someone about your problems and ended up prescribed medication.	1.96	1.12
You tried to figure out your insurance by calling back and forth between professionals and your insurance, but it became so overwhelming you just gave up.	1.95	1.07
It's hard for you to ask for any services or help because you're afraid you will just be put back on medications.	1.95	1.12
You are worried about the long-term effects of medications. You have heard of others who have stayed on medications who have serious medical issues as a result.	1.94	1.13
When you were first prescribed medications, no one explained why you were taking medications and any potential side effects.	1.93	1.16
You weren't able to continue participating in support groups because you kept moving to different areas to live.	1.92	1.08
At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	1.91	1.10
You were supposed to be switched to a counselor with an adult provider but the paperwork or communication didn't go through so you gave up.	1.90	1.12
You were kicked out of where you lived because of symptoms related to your mental health.	1.89	1.17
The doctors thought you were taking your medications, but you were not. They comment on the positive changes they've seen as a result of your medication.	1.87	1.11
If you complained about your medications or disagreed with the doctor, you were prescribed more medications or higher doses of ones you were already taking.	1.81	1.06
You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse.	1.81	1.08
You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	1.81	1.11

Appendix G (continued)

Your counselor would play cards or board games and would not really talk about things that were important to you.	1.79	1.04
You didn't continue mental health services after turning 18 because you would lose pay for missing work.	1.76	1.08
You went to the hospital when your mental health got really bad, but you just ended up with doctor's bills you can't pay.	1.63	1.00
You took too many medications and ended up in the hospital. Mental health providers felt it was a substance abuse issue but substance abuse providers thought it was a suicide attempt. Neither one wanted to help you.	1.63	1.01
You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	1.55	0.94
Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	1.52	0.99

APPENDIX H

TABLE OF DIFFICULT SITUATION MEAN FREQUENCIES

Means scores of the most frequently encountered difficult situations for former foster youth (n =121)

Situation	Mean	SD
You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	3.02	1.47
You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	2.82	1.46
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	2.81	1.21
Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	2.68	1.44
Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	2.63	1.57
You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	2.59	1.44
Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	2.51	1.53
You have a hard time trusting professionals because they change so frequently.	2.50	1.42
When you did contact people for help, you received mixed messages from different people, which left you confused.	2.46	1.40
After refusing to take your medications while in care, you were told privileges would be taken away if you refused to comply.	2.44	1.50
At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	2.42	1.49
It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	2.38	1.35
You had a transitional team composed of several people, but when you needed help you weren't sure who to contact.	2.38	1.37
The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	2.38	1.46
You felt like your counselor was not really listening when you wanted to talk. They seemed distracted or just took notes.	2.38	1.48

Appendix H (continued)

A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	2.38	1.52
Professionals may have discussed how to return to services after 18 if you decided you needed help, but you didn't remember what they told you to do or who to contact when you actually needed help.	2.32	1.43
You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	2.32	1.46
Medications made you feel sick. They made you feel loopy or groggy.	2.31	1.51
Your mental health diagnosis has changed multiple times since you first entered care. You don't feel any different.	2.29	1.44
Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	2.29	1.50
You were told you have to take your medications in order to remain in the program or receive other services. You felt you did not have a choice.	2.29	1.52
Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments.	2.28	1.44
Some medications helped calm you down, but they made you sleepy in school so you'd have to take another medication to wake you up.	2.28	1.57
Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	2.26	1.29
You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	2.25	1.46
It felt like people were putting you on medications to control you. You felt that medications were prescribed to make the foster parent or group home staff's job easier.	2.2	1.51
It's hard for you to ask for any services or help because you're afraid you will just be put back on medications.	2.17	1.40
You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	2.16	1.37

Appendix H (continued)

You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	2.15	1.36
You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse.	2.14	1.52
You tried to figure out your insurance by calling back and forth between professionals and your insurance, but it became so overwhelming you just gave up.	2.12	1.35
You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	2.08	1.31
You weren't able to continue participating in support groups because you kept moving to different areas to live.	2.07	1.30
When you were first prescribed medications, no one explained why you were taking medications and any potential side effects.	2.06	1.39
You feel like medications changed your personality.	2.06	1.40
You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	2.05	1.27
You were prescribed medication to help with one mood but then it caused a different mood and you were prescribed another medication to help with that.	2.05	1.33
You thought you had insurance but didn't know you needed to change your address each time you moved in order to remain covered.	2.05	1.34
You had insurance when you turned 18, but when you went to refill your prescription the pharmacy told you it was no longer covered.	2.05	1.36
You are worried about the long-term effects of medications. You have heard of others who have stayed on medications who have serious medical issues as a result.	2.01	1.36
You were prescribed medication for something that could be fixed by other methods. You went in to talk to someone about your problems and ended up prescribed medication.	2.01	1.38
At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	2.00	1.34
Your counselor would play cards or board games and would not really talk about things that were important to you.	1.98	1.27
The doctors thought you were taking your medications, but you were not. They comment on the positive changes they've seen as a result of your medication.	1.97	1.36

Appendix H (continued)

You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	1.91	1.36
If you complained about your medications or disagreed with the doctor, you were prescribed more medications or higher doses of ones you were already taking.	1.90	1.27
You didn't continue mental health services after turning 18 because you would lose pay for missing work.	1.88	1.35
You were kicked out of where you lived because of symptoms related to your mental health.	1.87	1.18
You were supposed to be switched to a counselor with an adult provider but the paperwork or communication didn't go through so you gave up.	1.86	1.24
You went to the hospital when your mental health got really bad, but you just ended up with doctor's bills you can't pay.	1.78	1.31
You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	1.75	1.31
You took too many medications and ended up in the hospital. Mental health providers felt it was a substance abuse issue but substance abuse providers thought it was a suicide attempt. Neither one wanted to help you.	1.56	0.98
Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	1.53	1.06

APPENDIX I

TABLE OF DIFFICULT SITUATION FREQUENCIES

Appendix I (continued)

Frequency of encountering difficult situations for former foster youth (n =121)

Situation	Frequency (Percent)				
	Never	1-2x/ year	1-2x/ month	1-2x/ week	1-2x/ day
You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	24(19.8)	20(16.5)	25(20.7)	16(13.2)	27(22.3)
Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	41(33.9)	19(15.7)	17(14)	11(9.1)	24(19.8)
You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	29(24)	20(16.5)	28(23.1)	12(9.9)	23(19)
Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	40(33.1)	20(16.5)	16(13.2)	9(7.4)	20(16.5)
Some medications helped calm you down, but they made you sleepy in school so you'd have to take another medication to wake you up.	55(45.5)	17(14)	10(8.3)	8(6.6)	20(16.5)
You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	33(27.3)	26(21.5)	25(20.7)	7(5.8)	20(16.5)
You took too many medications and ended up in the hospital. Mental health providers felt it was a substance abuse issue but substance abuse providers thought it was a suicide attempt. Neither one wanted to help you.	75(62)	16(13.2)	11(9.1)	5(4.1)	2(1.7)
You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse.	58(47.9)	20(16.5)	8(6.6)	4(3.3)	19(15.7)
Medications made you feel sick. They made you feel loopy or groggy.	54(44.6)	15(12.4)	19(15.7)	8(6.6)	18(14.9)
Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	49(40.5)	19(15.7)	16(13.2)	5(4.1)	18(14.9)

Appendix I (continued)

It felt like people were putting you on medications to control you. You felt that medications were prescribed to make the foster parent or group home staff's job easier.	55(45.5)	15(12.4)	16(13.2)	3(2.5)	18(14.9)
After refusing to take your medications while in care, you were told privileges would be taken away if you refused to comply.	47(38.8)	18(14.9)	19(15.7)	12(9.9)	18(14.9)
A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	49(40.5)	19(15.7)	14(11.6)	12(9.9)	18(14.9)
At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	45(37.2)	16(13.2)	21(17.4)	9(7.4)	17(14)
You have a hard time trusting professionals because they change so frequently.	34(28.1)	28(23.1)	20(16.5)	8(6.6)	17(14)
You were told you have to take your medications in order to remain in the program or receive other services. You felt you did not have a choice.	51(42.1)	15(12.4)	15(12.4)	8(6.6)	17(14)
Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	34(28.1)	19(15.7)	25(20.7)	17(14)	17(14)
You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	46(38)	20(16.5)	18(14.9)	7(5.8)	16(13.2)
You felt like your counselor was not really listening when you wanted to talk. They seemed distracted or just took notes.	47(38.8)	19(15.7)	17(14)	12(9.9)	16(13.2)
Your mental health diagnosis has changed multiple times since you first entered care. You don't feel any different.	49(40.5)	21(17.4)	17(14)	10(8.3)	15(12.4)
It's hard for you to ask for any services or help because you're afraid you will just be put back on medications.	50(41.3)	24(19.8)	15(12.4)	6(5)	14(11.6)
The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	47(38.8)	14(11.6)	20(16.5)	13(10.7)	14(11.6)

Appendix I (continued)

When you did contact people for help, you received mixed messages from different people, which left you confused.	37(30.6)	22(18.2)	22(18.2)	11(9.1)	14(11.6)
Professionals may have discussed how to return to services after 18 if you decided you needed help, but you didn't remember what they told you to do or who to contact when you actually needed help.	43(35.5)	24(19.8)	15(12.4)	10(8.3)	14(11.6)
Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments.	50(41.3)	21(17.4)	14(11.6)	14(11.6)	13(10.7)
You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	49(40.5)	16(13.2)	14(11.6)	11(9.1)	13(10.7)
You are worried about the long-term effects of medications. You have heard of others who have stayed on medications who have serious medical issues as a result.	57(47.1)	20(16.5)	14(11.6)	4(3.3)	12(9.9)
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	21(17.4)	22(18.2)	42(34.7)	18(14.9)	12(9.9)
It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	36(29.8)	27(22.3)	20(16.5)	10(8.3)	12(9.9)
When you were first prescribed medications, no one explained why you were taking medications and any potential side effects.	59(48.8)	15(12.4)	14(11.6)	9(7.4)	11(9.1)
You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	50(41.3)	18(14.9)	19(15.7)	7(5.8)	11(9.1)
You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	66(54.5)	14(11.6)	11(9.1)	6(5)	11(9.1)
You had a transitional team composed of several people, but when you needed help you weren't sure who to contact.	41(33.9)	21(17.4)	21(17.4)	14(11.6)	11(9.1)

Appendix I (continued)

You feel like medications changed your personality.	58(47.9)	17(14)	12(9.9)	10(8.3)	11(9.1)
You had insurance when you turned 18, but when you went to refill your prescription the pharmacy told you it was no longer covered.	58(47.9)	15(12.4)	17(14)	8(6.6)	10(8.3)
You thought you had insurance but didn't know you needed to change your address each time you moved in order to remain covered.	55(45.5)	20(16.5)	14(11.6)	8(6.6)	10(8.3)
The doctors thought you were taking your medications, but you were not. They comment on the positive changes they've seen as a result of your medication.	62(51.2)	14(11.6)	13(10.7)	8(6.6)	10(8.3)
At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	59(48.8)	17(14)	15(12.4)	7(5.8)	10(8.3)
You were prescribed medication to help with one mood but then it caused a different mood and you were prescribed another medication to help with that.	59(48.8)	14(11.6)	23(19)	6(5)	10(8.3)
You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	73(60.3)	14(11.6)	6(5)	5(4.1)	10(8.3)
You were prescribed medication for something that could be fixed by other methods. You went in to talk to someone about your problems and ended up prescribed medication.	61(50.4)	17(14)	10(8.3)	11(9.1)	10(8.3)
Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	44(36.4)	20(16.5)	27(22.3)	9(7.4)	9(7.4)
You tried to figure out your insurance by calling back and forth between professionals and your insurance, but it became so overwhelming you just gave up.	56(46.3)	11(9.1)	24(19.8)	9(7.4)	9(7.4)
You didn't continue mental health services after turning 18 because you would lose pay for missing work.	68(56.2)	12(9.9)	10(8.3)	9(7.4)	9(7.4)

Appendix I (continued)

You went to the hospital when your mental health got really bad, but you just ended up with doctor's bills you can't pay.	76(62.8)	10(8.3)	10(8.3)	7(5.8)	9(7.4)
You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	51(42.1)	17(14)	15(12.4)	13(10.7)	9(7.4)
You weren't able to continue participating in support groups because you kept moving to different areas to live.	53(43.8)	18(14.9)	19(15.7)	9(7.4)	8(6.6)
If you complained about your medications or disagreed with the doctor, you were prescribed more medications or higher doses of ones you were already taking.	64(52.9)	13(10.7)	19(15.7)	5(4.1)	8(6.6)
You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	55(45.5)	17(14)	20(16.5)	10(8.3)	8(6.6)
You were supposed to be switched to a counselor with an adult provider but the paperwork or communication didn't go through so you gave up.	62(51.2)	16(13.2)	14(11.6)	6(5)	7(5.8)
You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	56(46.3)	21(17.4)	19(15.7)	11(9.1)	7(5.8)
Your counselor would play cards or board games and would not really talk about things that were important to you.	59(48.8)	19(15.7)	16(13.2)	10(8.3)	7(5.8)
You were kicked out of where you lived because of symptoms related to your mental health.	57(47.1)	19(15.7)	14(11.6)	9(7.4)	4(3.3)
Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	80(66.1)	9(7.4)	10(8.3)	4(3.3)	4(3.3)

APPENDIX J

TABLE OF SUPPORTIVE SITUATION MEAN INTENSITIES

Most supportive situations for former foster youth (n =121)

Situation	Mean	SD
You have someone to call if things get really tough. You have a person who listens and gives you advice.	2.98	1.03
Having leadership opportunities helped you gain perspective with your own mental health.	2.80	1.07
You get to bond with other youth/young adults experiencing similar situations at programs which was helpful.	2.79	1.08
Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	2.69	0.95
You maintain your mental health by using distractions such as school, work, or other activities.	2.68	1.08
An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	2.62	1.04
Teachers or coaches at your school provided emotional support and encouraged you.	2.53	1.07
It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	2.52	1.07
You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	2.52	1.11
You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	2.46	1.11
Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	2.44	1.11
You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	2.44	1.11
Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	2.42	1.05
A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	2.42	1.07
Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	2.39	1.08
You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	2.29	1.13

Appendix J (continued)

You were able to meet your own mental health needs through finding resources on your own by looking them up or joining support groups.	2.26	1.09
You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	2.26	1.23
You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	2.22	1.13
You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18.	2.22	1.16
After 18, you don't have to tell everyone you have a mental health diagnosis. You have a fresh start.	2.21	1.18
You were able to return to services after 18, because you still knew another youth in care who helped connect you to people.	2.12	1.10
Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed you a chance to make more independent decisions while still being supported.	2.10	1.08
Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	2.07	1.09
An adult from a religious community/church took the time to get to know you and maintained contact with you after 18.	2.04	1.15
You can take care of your own mental health needs, through marijuana, which calms you down.	2.03	1.20
Returning to your biological family was helpful because they supported you emotionally. They understood you.	2.00	1.16
Mentors went to court with you even after you turned 18. Just knowing somebody supported you and would make sure you were treated fairly was a relief.	1.93	1.12
The medication you're prescribed helps you concentrate and/or manage your moods.	1.89	1.09
You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	1.83	1.07
You were able to get back into services by going to the emergency room or utilizing crisis services.	1.63	1.00
Your doctor knew you weren't going to continue taking medications after turning 18, so they helped you get off of them gradually.	1.60	0.94

APPENDIX K

TABLE OF SUPPORTIVE SITUATION MEAN FREQUENCIES

Means scores of the most frequently encountered supportive situations for former foster youth (n =121)

Situation	Mean	SD
Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	3.48	1.34
You have someone to call if things get really tough. You have a person who listens and gives you advice.	3.40	1.45
You maintain your mental health by using distractions such as school, work, or other activities.	3.08	1.57
You get to bond with other youth/young adults experiencing similar situations at programs which was helpful.	3.02	1.41
You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	3.01	1.41
Teachers or coaches at your school provided emotional support and encouraged you.	2.98	1.43
Having leadership opportunities helped you gain perspective with your own mental health.	2.95	1.38
It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	2.89	1.45
You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	2.79	1.47
An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	2.77	1.38
A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	2.76	1.35
You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	2.74	1.44
Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	2.66	1.40
Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	2.63	1.33
Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	2.51	1.25
You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	2.51	1.50

Appendix K (continued)

You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18.	2.40	1.43
You were able to meet your own mental health needs through finding resources on your own by looking them up or joining support groups.	2.38	1.47
Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed you a chance to make more independent decisions while still being supported.	2.35	1.37
You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	2.29	1.31
You can take care of your own mental health needs, through marijuana, which calms you down.	2.27	1.53
You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	2.26	1.53
After 18, you don't have to tell everyone you have a mental health diagnosis. You have a fresh start.	2.23	1.36
The medication you're prescribed helps you concentrate and/or manage your moods.	2.18	1.54
Returning to your biological family was helpful because they supported you emotionally. They understood you.	2.17	1.43
An adult from a religious community/church took the time to get to know you and maintained contact with you after 18.	2.17	1.46
Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	2.11	1.21
You were able to return to services after 18, because you still knew another youth in care who helped connect you to people.	1.99	1.13
Mentors went to court with you even after you turned 18. Just knowing somebody supported you and would make sure you were treated fairly was a relief.	1.99	1.36
You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	1.97	1.24
Your doctor knew you weren't going to continue taking medications after turning 18, so they helped you get off of them gradually.	1.72	1.21
You were able to get back into services by going to the emergency room or utilizing crisis services.	1.59	1.07

APPENDIX L

TABLE OF SUPPORTIVE SITUATION FREQUENCIES

Frequency of encountering supportive situations for former foster youth (n =121)

Situation	Frequency (Percent)				
	Never	1-2x/ year	1-2x/ month	1-2x/ week	1-2x/ day
You have someone to call if things get really tough. You have a person who listens and gives you advice.	17(14)	11(9.1)	23(19)	19(15.7)	34(28.1)
Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	12(9.9)	12(9.9)	28(23.1)	21(17.4)	33(27.3)
You maintain your mental health by using distractions such as school, work, or other activities.	25(20.7)	19(15.7)	15(12.4)	16(13.2)	31(25.6)
You get to bond with other youth/young adults experiencing similar situations at programs which was helpful.	21(17.4)	18(14.9)	28(23.1)	16(13.2)	23(19)
Teachers or coaches at your school provided emotional support and encouraged you.	25(20.7)	14(11.6)	28(23.1)	20(16.5)	21(17.4)
You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	25(20.7)	11(9.1)	30(24.8)	22(18.2)	20(16.5)
It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	25(20.7)	16(13.2)	25(20.7)	15(12.4)	20(16.5)
Having leadership opportunities helped you gain perspective with your own mental health.	20(16.5)	21(17.4)	25(20.7)	18(14.9)	19(15.7)
You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	52(43)	14(11.6)	15(12.4)	5(4.1)	18(14.9)
You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	30(24.8)	18(14.9)	19(15.7)	20(16.5)	18(14.9)
You can take care of your own mental health needs, through marijuana, which calms you down.	56(46.3)	9(7.4)	18(14.9)	8(6.6)	17(14)

Appendix L (continued)

You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	33(27.3)	12(9.9)	30(24.8)	16(13.2)	17(14)
You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	43(35.5)	15(12.4)	20(16.5)	14(11.6)	17(14)
The medication you're prescribed helps you concentrate and/or manage your moods.	61(50.4)	7(5.8)	14(11.6)	9(7.4)	16(13.2)
You were able to meet your own mental health needs through finding resources on your own by looking them up or joining support groups.	43(35.5)	18(14.9)	19(15.7)	8(6.6)	16(13.2)
Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	32(26.4)	16(13.2)	27(22.3)	16(13.2)	14(11.6)
An adult from a religious community/church took the time to get to know you and maintained contact with you after 18.	57(47.1)	5(4.1)	22(18.2)	7(5.8)	13(10.7)
A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	28(23.1)	13(10.7)	33(27.3)	18(14.9)	13(10.7)
Mentors went to court with you even after you turned 18. Just knowing somebody supported you and would make sure you were treated fairly was a relief.	57(47.1)	20(16.5)	12(9.9)	4(3.3)	12(9.9)
An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	28(23.1)	17(14)	26(21.5)	24(19.8)	12(9.9)
Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	29(24)	21(17.4)	28(23.1)	16(13.2)	12(9.9)
You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18.	41(33.9)	21(17.4)	15(12.4)	16(13.2)	12(9.9)
Returning to your biological family was helpful because they supported you emotionally. They understood you.	52(43)	18(14.9)	12(9.9)	11(9.1)	12(9.9)
After 18, you don't have to tell everyone you have a mental health diagnosis. You have a fresh start.	47(38.8)	20(16.5)	21(17.4)	9(7.4)	11(9.1)

Appendix L (continued)

Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed you a chance to make more independent decisions while still being supported.	40(33.1)	23(19)	18(14.9)	13(10.7)	11(9.1)
Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	30(24.8)	24(19.8)	28(23.1)	18(14.9)	7(5.8)
You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	44(36.4)	14(11.6)	27(22.3)	13(10.7)	7(5.8)
You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	56(46.3)	16(13.2)	19(15.7)	8(6.6)	6(5)
Your doctor knew you weren't going to continue taking medications after turning 18, so they helped you get off of them gradually.	72(59.5)	10(8.3)	12(9.9)	6(5)	6(5)
Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	48(39.7)	17(14)	27(22.3)	9(7.4)	5(4.1)
You were able to return to services after 18, because you still knew another youth in care who helped connect you to people.	50(41.3)	20(16.5)	27(22.3)	5(4.1)	4(3.3)
You were able to get back into services by going to the emergency room or utilizing crisis services.	74(61.2)	13(10.7)	11(9.1)	4(3.3)	4(3.3)

APPENDIX M

FULL TABLE OF CHALLENGING SITUATION FACTOR LOADINGS

Factor loadings based on a maximum likelihood extraction analysis with varimax rotation for the challenging situations (n = 121)

Factor and Item	Question	Loading								
Factor 1										
MM1	When you did contact people for help, you received mixed messages from different people, which left you confused.	.45	.17	.63	.23	.20	.15	.17	.11	.02
MM2	Some staff are in your business when things are going wrong, but do not have the time to talk to you when you seek them out.	.49	.25	.5	.13	.36	.02	.22	.09	-.07
MM3	You have a hard time trusting professionals because they change so frequently.	.43	.40	.37	.3	.25	.10	.19	.12	-.06
MM4	You seem to get stricter consequences than your same age peers who are not involved in mental health services. If you were to get upset and punch a wall, the police would be called.	.48	.27	.09	.35	.13	.02	.31	-.04	.29
MM5	Professionals may have discussed how to return to services after 18 if you decided you needed help, but you didn't remember what they told you to do or who to contact when you actually needed help.	.85	.14	.21	.06	.14	.32	-.05	.05	.15
MM6	Adults such as counselors, group home staff, foster parents, and teachers judge you by your mental health diagnosis. It feels like they assume you're a troubled youth before getting to know you.	.50	.35	.17	.28	.06	.12	.09	.14	.11
MM7	Staff told you to avoid the negative stereotypes of youth aging out of foster care like becoming homeless or dropping out of school, but didn't talk about how to avoid them. You feel like you were set up to fail.	.42	.29	.38	.35	.17	.17	.26	.07	.08

Appendix M (continued)

Item	Statement									
MM8	It seems like youth get the same services when they come into foster care. You received counseling and medications because that's what all foster youth receive.	.56	.17	.08	.18	.24	.14	.39	.05	.04
MM9	At 16 my needs were different than they were at 20, but the programs didn't seem to meet my needs as I got older.	.57	.25	.34	.26	.11	.21	.19	.18	.01
MM10	A counselor promised what you said in session was confidential, however your caseworker and other members of your team always seemed to know what you talked about afterward.	.49	.12	.25	.10	.15	.07	.52	.11	.22
Factor 2										
CV1	Your probation required that you participated in services, but you were not able to get to appointments after turning 18 so you were sent back to jail.	.09	.73	.10	.06	.2	.06	.11	.45	-.10
CV2	You weren't allowed to continue independent living/transition services after 18 because you didn't have an adult diagnosis and were no longer eligible for services.	.24	.77	.14	.10	.06	.14	.08	.22	.13
CV3	You were kicked out of where you lived because of symptoms related to your mental health.	.05	.75	.17	.08	.10	.18	.17	-.05	.10
CV4	You had someone speaking/making decisions about services for you while in care, so you didn't really know how to advocate for yourself after turning 18.	.38	.41	.17	.17	.16	.17	.32	.14	-.02
CV5	You go to groups where you're supposed to have a voice, but services remain the same. You don't feel like people are genuinely listening to your concerns.	.25	.40	.09	.18	.79	.08	.15	-.13	.26
Factor 3										
AS1	At first it was difficult to talk to a counselor but when you decided you were ready to talk, you were not able to get counseling because you couldn't afford it.	.04	.20	.43	.03	.06	.18	.02	.72	.05
AS2	You didn't continue mental health services after turning 18 because you would lose pay for missing work.	.14	.66	.51	.09	.06	-.05	.15	.14	.03

Appendix M (continued)

AS3	You don't follow up with appointments because you usually don't have anyone to ask for a ride or no longer have a bus pass.	.21	.23	.53	.15	.16	.28	.08	.23	.18
AS4	You moved to a different area and were no longer able to get to service appointments because you didn't have consistent transportation.	.04	.12	.58	.37	.23	.29	.09	.19	.14
AS5	You stopped counseling after turning 18 because you would have to switch counselors. You didn't want to tell your story again.	.10	.27	.60	.19	.10	.30	.09	.05	.11
Factor 4										
OV1	You have too much to worry about after leaving care, to focus on your mental health right away. You have to figure out where you're going to live, get a job, and manage your money, first.	.38	.03	.28	.62	.03	.14	.22	.13	.10
OV2	Nobody was there for you when life got tough after turning 18. You were surrounded by people while in care, but felt very isolated after leaving care.	.22	.11	.21	.80	.19	.05	.22	.08	.08
OV3	You didn't feel prepared to be successful on your own, but you didn't feel like you could ask for help because you're supposed to be independent after 18.	.07	.14	.18	.77	.16	.20	.13	.03	.07
Factor 5										
ID1	The only other young adults you know to live with are other former foster youth, who are struggling with their own mental health issues.	.17	.04	.33	.21	.45	.20	.17	.16	-.02
ID2	You decide not to continue mental health services after 18 because you don't want to be associated with the child welfare/foster care system.	.34	.37	.35	.19	.44	-.07	-.07	.19	-.05
ID3	Group counseling turns into a hangout or mini-party, which is good to connect with other youth in similar situations, but you want more support and activities to help you develop skills.	.11	.08	.18	.06	.50	.14	.11	.15	-.07

Appendix M (continued)

Factor 6									
You weren't able to continue participating in support groups because you kept moving to different areas to live.	.25	.18	.09	.33	.15	.42	.29	.15	.11
You tried to figure out your insurance by calling back and forth between professionals and your insurance, but it became so overwhelming you just gave up.	.24	-.02	.35	.10	.10	.88	.04	.05	-.01
You thought you had insurance but didn't know you needed to change your address each time you moved in order to remain covered.	.15	.19	.17	.19	.15	.49	.16	.17	-.10
Factor 7									
Your counselor would play cards or board games and would not really talk about things that were important to you.	-.14	.03	.27	.23	.38	.07	.54	.09	.13
You felt like your counselor was not really listening when you wanted to talk. They seemed distracted or just took notes.	.25	.23	.03	.25	.02	.12	.66	.02	.05
Factor 8									
You went to the hospital when your mental health got really bad, but you just ended up with doctor's bills you can't pay.	.27	.40	-.13	.24	.27	.13	.08	.65	.24
Factor 9									
Your mental health diagnosis has changed multiple times since you first entered care. You don't feel any different.	.33	.30	.20	.26	.03	-.05	.23	.21	.77
You coped with the stress of living on your own by using drugs or alcohol, but it made the situation worse.	.33	.59	.18	.05	.19	-.08	-.03	-.04	.23
Your counselor continued to bring up things you didn't want to talk about. It made you uncomfortable and eventually, you stopped going to appointments.	.25	.10	.44	.24	.35	.23	.08	.02	.18

Appendix M (continued)

You learned quickly not to cause problems or question authority while in care, but now you're not sure how to advocate for yourself.	.40	.15	.30	.20	.11	.28	.17	-.03	.20
You were supposed to be switched to a counselor with an adult provider but the paperwork or communication didn't go through so you gave up.	.29	.38	.19	.18	.33	.33	.09	.16	.10
Decisions about your well-being were made behind closed-doors. Adults such as your caseworker, a supervisor, foster parent, or counselor made decisions without you.	.19	.06	.34	.28	.14	.11	.36	-.11	0

APPENDIX N

FULL TABLE OF SUPPORTIVE SITUATION FACTOR LOADINGS

Factor loadings based on a principle factor extraction analysis with varimax rotation for the supportive situations (n = 121)

Factor and Item	Question	Loading								
Factor 1										
RE1	A professional took the time to break down tasks into steps and repeated things you would need to know on your own.	0.61	0.10	0.07	0.03	0.06	0.15	0.23	0.06	0.09
RE2	Your doctor/counselor was able to meet you at different service locations, depending on where you lived at the time.	0.47	0.01	0.05	0.18	0.21	0.16	0.25	0.29	0.07
RE3	An adult such as a caseworker, counselor, or mentor went with you to accomplish tasks for the first time, to walk you through the process.	0.78	0.07	0.11	0.02	0.15	0.05	0.07	0.25	0.07
RE4	You had a mentor/staff who helped you learn how to advocate for yourself. They helped you prepare for meetings so you felt confident in communicating your concerns and questions.	0.65	0.02	0.28	0.19	0.13	0.05	0.02	0.13	0.02
RE5	It felt like professionals trusted your decisions and believed in your ability to manage your own emotions and behaviors.	0.74	0.23	0.00	0.12	0.24	0.03	0.03	0.01	0.01
RE6	Teachers or coaches at your school provided emotional support and encouraged you.	0.44	0.00	0.04	0.38	0.06	0.07	0.03	0.04	0.01
RE7	You mentor other youth in similar situations by listening and giving advice when needed, which made you feel good.	0.56	0.10	0.21	0.29	0.05	0.28	0.18	0.14	0.04
Factor 2										
ST1	You had the same counselor or doctor after you turned 18. They already knew your story and how best to support you.	0.44	0.49	0.03	0.05	0.26	0.01	0.04	0.38	0.08
ST2	You received transition services that continued after you turned 18, which made you feel like you had someone to ask for help when needed.	0.37	0.43	0.28	0.03	0.06	0.23	0.19	0.01	0.05

Appendix N (continued)

ST3	Your services transferred to the adult system without issue because you had a professional such as a caseworker or counselor help make sure you were set up.	0.07	0.72	0.26	0.05	0.05	0.10	0.15	0.08	0.02
Factor 3										
OM1	Mentors stay with you even after the professionals are gone. They keep in contact with you and really care about how you're doing.	0.30	0.08	0.51	0.02	0.03	0.43	0.18	0.03	0.15
OM2	Staff who had an ongoing relationship with you were able to point out the progress you've made over time as well as notice when you were struggling.	0.48	0.17	0.47	0.19	0.05	0.08	0.20	0.05	0.03
OM3	You still talk to your group home staff or foster parents, even though you've left. They check in on you and care about how you're doing.	0.12	0.17	0.69	0.04	0.05	0.04	0.09	0.12	0.11
Factor 4										
SE1	You stopped mental health services because you decided to take control and manage your own symptoms, emotions, and behaviors.	0.05	0.14	0.12	0.49	0.61	0.03	0.00	0.03	0.27
SE2	You continued mental health services after 18 because they were on your own terms this time. You decided you wanted help and could choose what was a good fit for you.	0.14	0.46	0.12	0.41	0.02	0.22	0.02	0.27	0.05
SE3	Once you were on your own, you were able to make decisions and allowed to make mistakes. You learned from them and were able to decide what was best for you.	0.06	0.24	0.20	0.50	0.13	0.18	0.09	0.00	0.15
SE4	You maintain your mental health by using distractions such as school, work, or other activities.	0.23	0.16	0.05	0.58	0.02	0.18	0.10	0.08	0.08
Factor 5										
	You were able to get back into services by going to the emergency room or utilizing crisis services.	0.03	0.01	0.01	0.23	0.66	0.04	0.19	0.05	0.16

Appendix N (continued)

	You can take care of your own mental health needs, through marijuana, which calms you down.	0.13	0.03	0.02	0.02	0.81	0.04	0.11	0.08	0.09
Factor 6										
	Having leadership opportunities helped you gain perspective with your own mental health.	0.10	0.27	0.05	0.11	0.07	0.77	0.12	0.09	0.18
	You get to bond with other youth/young adults experiencing similar situations at programs which was helpful.	0.27	0.00	0.26	0.24	0.07	0.65	0.01	0.01	0.14
Factor 7										
	You were leading your own team meetings before you were 18, which helped your confidence in making decisions after turning 18.	0.26	0.12	0.06	0.13	0.08	0.08	0.60	0.18	0.43
	You were able to return to services after 18, because you still knew another youth in care who helped connect you to people.	0.25	0.16	0.12	0.12	0.08	0.12	0.73	0.23	0.00
Factor 8										
	Staying in the group home or foster placement after 18 made it easier to transition to the real world. It allowed you a chance to make more independent decisions while still being supported.	0.21	0.14	0.03	0.10	0.12	0.07	0.11	0.76	0.09
	Mentors went to court with you even after you turned 18. Just knowing somebody supported you and would make sure you were treated fairly was a relief.	0.26	0.09	0.14	0.02	0.01	0.04	0.28	0.50	0.06
Factor 9	After 18, you don't have to tell everyone you have a mental health diagnosis. You have a fresh start.	0.03	0.05	0.06	0.02	0.10	0.16	0.00	0.12	0.60
	An adult from a religious community/church took the time to get to know you and maintained contact with you after 18.	0.14	0.29	0.34	0.14	0.20	0.17	0.02	0.08	0.56

Appendix N (continued)

Returning to your biological family was helpful because they supported you emotionally. They understood you.	0.11	0.16	0.07	0.07	0.17	0.21	0.23	0.19	0.38
You were able to meet your own mental health needs through finding resources on your own by looking them up or joining support groups.	0.03	0.07	0.09	0.12	0.19	0.10	0.23	0.19	0.37
You have someone to call if things get really tough.									
You have a person who listens and gives you advice.	0.36	0.32	0.16	0.17	0.15	0.20	0.00	0.10	0.10

APPENDIX O

INSTITUTIONAL REVIEW BOARD APPROVALS

EXEMPTION GRANTED

Cynthia Lietz
Social Work, School of
520/884-5507
clietz@asu.edu

Dear Cynthia Lietz:

On 3/19/2014 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Uncharted Territory: Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care
Investigator:	Cynthia Lietz
IRB ID:	STUDY00000801
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Uncharted Territory focus group consent.pdf, Category: Consent Form; • Uncharted Territory Info Letter_consent interview.pdf, Category: Consent Form; • Uncharted Territory IRB Protocol, Category: IRB Protocol; • Uncharted Territory Letter of Support JFCS.pdf, Category: Off-site authorizations (school permission, other IRB approvals, Tribal permission etc); • Uncharted Territory Focus Group Questions.pdf, Category: Other (to reflect anything not captured above); • Individual interviews with community members will consist of three guiding questions.pdf, Category: Other (to reflect anything not captured above); • Uncharted Territory Recruitment Script Focus Group .pdf, Category: Recruitment Materials; • Qualtrics Uncharted Territory Survey 031714.pdf, Category: Recruitment Materials; • Uncharted Territory Recruitment Script Interview.pdf, Category: Recruitment Materials;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 3/19/2014.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Megan Hayes
Megan Hayes

ASU Knowledge Enterprise Development

EXEMPTION GRANTED

Cynthia Lietz
Social Work, School of
602/496-0404
clietz@asu.edu

Dear Cynthia Lietz:

On 7/17/2014 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Uncharted Territory (Phase II): Experiences of Foster Youth Navigating the Mental Health System as they Age Out of Care
Investigator:	Cynthia Lietz
IRB ID:	STUDY00001313
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• UT CONSENT Agency 071714.pdf, Category: Consent Form; • UT CONSENT Conference 071714.pdf, Category: Consent Form; • UT CONSENT Online 071714.pdf, Category: Consent Form; • IRB protocol Uncharted Territory, PHASE II, 071614.docx, Category: IRB Protocol; • UT Phase II Survey, 071714.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions);

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 7/17/2014.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Megan Hayes
Megan Hayes
Craig Lecroy