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Conceptualizing the Step-Down for Foster Youth Approaching Adulthood: Perceptions of Service Providers, Caseworkers, and Foster Parents

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Abstract

Studies find considerable movement between residential treatment and less restrictive foster home settings, with approximately half of foster youth who are stepped down eventually returning to a higher level of care. Very little is known about the step down for foster youth who are approaching adulthood in locked residential facilities. A qualitative study of stepping down a small sample of foster youth, as perceived by team members delivering a model of treatment foster care, is presented. These findings reveal the dimensions of stepping down foster youth at the onset of adulthood, and highlight the importance of providing foster youth with developmental opportunities to engage in the social roles and tasks of late adolescence and/or early adulthood. Implications for further refining the concept of stepping down from a developmental perspective are discussed.

Keywords

Stepping down; treatment foster care; foster youth with mental health conditions; service providers; aging out of foster care

Older foster youth with mental health conditions who reach the age of majority in the child welfare system face the transition to adulthood with heightened risks and vulnerability. Of concern is a pattern of services that are intensive in the year prior to reaching adulthood, including locked residential treatment settings (Courtney et al., 2001; Courtney et al., 2001; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001); inpatient hospitalizations (McMillen & Tucker, 1999; McMillen et al., 2004); and juvenile detention or corrections (Courtney,

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Terao, & Bost, 2004). Growing awareness of the negative effects of long stays in residential treatment on adolescent development (Dmitrieva, Monahan, Cauffman, & Steinberg, 2012); the quick transitions older foster youth make from residential to less restrictive settings (McCoy, McMillen, & Spitznagel, 2008) and the lack of coordination between child and adult service systems (McMillen et al., 2004; McMillen & Raghavan, 2009) has increased the search for more preventative, community-centered, and developmentally congruent service alternatives that increase opportunities for foster youth to participate fully in community settings with intensive supports.

Currently, there are no evidence supported interventions or effective models of coordinated care to assist in the transition to less restrictive care settings. The few guidelines that specify the conditions or relevant factors to consider when stepping down foster youth further contributes to a lack of clear policy.¹ Without clear policy and programming, foster youth may be at risk for extended stays in contexts that have adverse consequences on their development (Dmitrieva et al., 2012). Placement into locked residential settings separates foster youth from their families, and exposes them to other youth who are troubled at a time in development when both are highly influential. Mental health conditions and other co-occurring disorders may further exacerbate their ability to cope.

Rather than reflecting a dynamic process of movement across placement settings and levels of restriction, a review of the research in child welfare underscores the ways in which the step down has been primarily treated as a singular event. For instance, among child welfare administrators, a step down to a less restrictive setting is considered to be a positive discharge. However, when foster youth are asked the experience is described as being less positive, reflecting a move that is forced and lacking in logic (Hyde & Kammerer, 2009). Yet another view of the step down comes from studies that find that as many as half of foster youth who are stepped down to less restrictive placement settings eventually return to higher levels of care (Budde et al., 2004; Farmer, Wagner, Burns, & Richards, 2003). For foster youth who are approaching adulthood, a lack of consensus among child welfare researchers, administrators, and practitioners concerning whether it is best to place foster youth into yet another temporary placement before adulthood adds complexity to our measure of success. This suggests that additional conceptual and methodological work is needed to identify and define multiple dimensions of the step down process.

In this paper, we describe a qualitative study of the step down process as viewed from the perspective of a team (i.e. foster parents, service providers, and caseworkers) delivering treatment foster care (TFC) services. To identify and further refine the conceptualization of the step down for foster youth approaching adulthood we ask: 1) How do team members perceive the step down for foster youth? 2) What dimensions of the step down are perceived of as being important? The following section describes the treatment foster care model generally, and the Multidimensional Treatment Foster Care model more specifically. Attention is given treatment considerations that may be unique for foster youth approaching adulthood from locked residential settings.

Stepping Down to Treatment Foster Care

Treatment foster care is considered to be the least restrictive treatment based residential option for youth with serious emotional and behavioral disorders (Curtis, Alexander, & Lunghofer, 2001). Originating in the 1950's as a short-term transitional program for children returning to families from residential treatment programs (Reddy & Pfeiffer, 1997; Wells,

¹A review of several online state policy manuals suggests that guidelines for placement into a restrictive placement may be more common that the steps that are needed to step youth down to a less restrictive setting.

Farmer, Richards, & Burns, 2004), treatment foster care programs began to flourish after the late 1960's following the push for deinstitutionalization (Hawkins, Meadowcroft, Trout, & Luster, 1985). They have since emerged as a preferred placement over institutional settings, with approximately 2,000 programs providing TFC across the United States (Farmer, Burns, Wagner, Murray, & Southerland, 2010). The majority of these programs, however, do not provide the model that is empirically supported (Dorsey et al., 2008; Farmer, Burns, Dubs, & Thompson, 2002; Farmer, Wagner, Burns, & Richards, 2003).²

The widespread attention that has promoted treatment foster care as an evidence-supported intervention has been heavily influenced by Chamberlain and colleagues at the Oregon Social Learning Center. In 1998, the Multidimensional Treatment Foster Care (MTFC) model was selected as a National Model Program by the Office of Juvenile Justice and Delinquency Prevention (Chamberlain & Mihalic, 1998), and has been highlighted on in the U.S. Surgeon General's report as a model program (Chamberlain, 2003). In 1999, the Washington State Institute for Public Policy (WSIPP) described MTFC as a cost-effective alternative to institutional and residential care (Aos, Phipps, Barnoski, & Lieb, 2001). In 2004, the Center for Disease Control called MTFC a model for the prevention of violence.

Drawing from early treatment foster care programs (PRYDE; (Hawkins et al., 1985) and several decades of research on the development and treatment of delinquency (Smith, Chamberlain, & Eddy, 2010), MTFC was developed to provide youth with opportunities to successfully live in the community through the delivery of intensive supports and the simultaneous strengthening of skills of biological parents or other caregivers. The intervention strategically targets factors contributing to the development, maintenance and escalation of delinquency and anti-social behaviors, such as exposure to delinquent peers. Over time the benefits of the MTFC intervention have been extended to prevent several outcomes including substance use (Smith et al., 2010), pregnancy (Kerr, Leve, & Chamberlain, 2009), and violence (Hahn et al., 2004). Findings from randomized controlled experiments promote the MTFC model as being as effective with older (up to age 19) as it is with younger aged juveniles (Chamberlain & Reid, 1998).

The evidence base for the MTFC model comes from four randomized control studies that have compared the effects of MTFC with usual care or any congregate care facility for juvenile delinquents (Chamberlain, 1990; Chamberlain & Reid, 1991; Chamberlain & Reid, 1998; Leve, Chamberlain, & Reid, 2005). A review of these studies finds that the samples from which program effects have been reported primarily rely on youth who are Caucasian, residing in one region of a Western state, and primarily referred due to juvenile justice system involvement as opposed to child welfare system involvement. The generalizability of findings to other populations should therefore be interpreted carefully.

A handful of qualitative studies have sought to understand the process and structure of treatment foster care programs from the perspective of treatment foster care providers (Castellanos-Brown & Lee; 2010; Jivanjee, 1999; Wells & D'Angelo, 1994; Wells, Farmer, Richards, & Barth; 2004). These studies reveal the intense demands that are placed on treatment foster parents, typically mothers, in caring for youth with serious emotional and behavioral condition. Common frustrations include the receipt of limited background information; a lack of control or say in what happens to foster youth; and managing emotions and behaviors in the home (Wells & D'Angelo, 1994; Wells et al., 2004). In addition to the frustrating dimensions of caregiving, two studies discuss the positive or

²Recent efforts to enhance treatment foster care in usual care settings demonstrate significant improvements in symptoms, behaviors, and strengths when compared to youth in the control group (Farmer, Burns, Wagner, Murray, and Southerland, 2010).

gratifying aspects of caregiving, including the rewards that come with viewing growth and change (Castellanos-Brown & Lee, 2010; Wells et al., 2004).

Although these studies have contributed to our understanding of the experiences of foster mothers, none of them focus on the experience of providing treatment foster care to a sample of foster youth approaching adulthood. Viewing the goals of treatment foster care within a broader developmental lens may offer a critical opportunity for developing strategies that promote development and address skills for the transition to adulthood.

Stepping Down Older Foster Youth to Treatment Foster Care

The context surrounding service provision of transition aged foster youth with mental health conditions identifies several aspects of treatment in need of careful consideration. First, the relationship that develops in TFC programs is based on a professional relationship where the professionals are typically adult experts. Although the TFC intervention is commonly described in the literature as being individualized, there is a paucity of information concerning how the voices of key stakeholders, such as foster youth, are incorporated into the plan for treatment, if at all.

An equally important consideration has to do with the treatment philosophy maintained by private agencies delivering TFC and the provision of services that are based on this orientation. One goal of TFC may be to eliminate gaps and the duplication of services. This may be particularly true as systems and agencies are being increasingly held accountable for cutting costs and demonstrating evidence. Yet, duplication of services may also strengthen the potency of an intervention. In the case of foster youth stepping down from restrictive care settings, studies find that service providers and youth alike express concern about the quality of independent living preparation provided in congregate care settings and the few opportunities that are provided to practice skills in the real world (Barth, 2002; Freundlich & Avery, 2006; Geenen & Powers, 2007; Scannapieco, Connell-Carrick, & Painter, 2007). Therefore, it could be that some replication of independent skills training is beneficial.

Another difference may lie in the pressure to intervene when the needs of youth are high and the onset of adulthood is approaching rapidly. Rather than being able to carefully orchestrate the transition from a locked setting to the community as is the preferred approach in the TFC model, there may be few homes that are available to care for older youth or meet eligibility criteria for caring for no other children. Plans for treatment may be compromised by a rush to act when needs are insufficiently understood. The learning that comes from the strategies used to understand foster youth has the potential to inform understanding and develop best practices.

Methods

Data were collected as part of a qualitative study designed with several interrelated goals: to illuminate experiences of the step down for aging out foster youth and to identify the dimensions of stepping down from residential care to treatment foster care from the perspective of team members. Therefore, the study that is presented focuses on identifying and describing key dimensions in the step down process. Data collection and analysis procedures were reviewed and approved by the institutional review boards of the authors' home institutions and the agency hosting the research.

Agency Context

Foster youth in this study were recruited from a private, non-profit agency that was contracted with the state to deliver specialized services to foster children with severe

emotional, behavioral and medical conditions. Private agency care managers carried smaller caseloads, typically ten to twelve cases, than state agency case workers. Private agency case managers were required to make weekly home visits. The specialized foster care program utilized an intensive case management and wrap around approach in which extensive supports were placed around a child and coordinated through monthly planning meetings that included family members and service providers. Within this agency, residential care is viewed as a last resort and used only when safety is determined to be a significant concern. The program's approach emphasizes helping foster parents to understand behaviors secondary to maltreatment as opposed to teaching foster parents how to use behavioral strategies.

The Intervention

The model of treatment foster care was built from the Multidimensional Treatment Foster Care (MTFC) model (Chamberlain, 2002), and adapted to address the needs of older foster youth in residential care who are without families to care for them and are approaching adulthood. The TFC model that is the focus of this study is nevertheless substantially different from the rigorously tested MTFC model, and should not be construed to be MTFC or an adapted version of MTFC. For the youth participants in this study, core elements of the TFC model included weekly office based therapy; weekly skill building in the community; close supervision and gradual lessening of restrictions in a family home; consistent teaching oriented discipline; recreational interest development and exposure to community organizations and institutions; and psychiatric consultation. For the treatment foster parents in this study, core elements of the TFC model included pre-service training; pre-placement visitation and coordination; coordination between school and home through a behavioral checklist; daily weekday telephone contact from the program to collect data on behaviors; weekly support meetings with other treatment foster parents; 24-hour a day/7 days a week on call access to service providers; crisis intervention, and respite. The places where the program differed from other TFC programs include the addition of a psychiatric nurse, and a different focus for the family consultant, the therapist role, the behavioral management program, and the foster parent training. Table 1 provides a detailed description of these roles.

Service Providers

The service providers who are the focus of this study were hired for the sole purpose of the study. These members included three program managers, only one of whom provided 24-hour support to all treatment foster parents and was not an employee of the agency from which the sample was recruited; two-therapists who met weekly with the youth participants for one hour in an office setting; two-family consultants who attempted to find and engage extended family members; a psychiatric nurse to review clinical records, identify the primary diagnoses, and provide written and verbal consultation for team members and youth; and two skills coaches who met weekly with youth in the community for two hours to initiate recreation and skill building. Among the ten team members (i.e. described above) who provided treatment services to the seven foster youth, three team members were African American and the remaining were Caucasian. All team members were female. Because the time from training in the delivery of the TFC intervention to recruitment of study participants spanned over one and one half years, turnover occurred in several positions including one program manager, one therapist, one family consultant, and two skills-coaches.³

³Both of the original skills coaches never worked directly with youth so were not interviewed for this study.

Foster Parent Recruitment

The treatment foster parents in this study were recruited through a variety of methods including word of mouth; and advertisements placed in newspapers and through Craig's List. In addition, foster parents of the private agency, who were licensed or on the way to becoming licensed, were also recruited into the study. A representative of the private agency was selected to field inquiries and to manage placement decisions within the agency and with fellow caseworkers. A preference was initially placed on identifying caregivers with only one other child in the home. However, this requirement was eventually relaxed due to the low number of eligible participants. Therefore all of the youth in this study were placed into homes with other foster children and/or biological/adopted children.

Sampling and Data Collection

Participation criteria restricted the sample to adolescents between the ages of 16 and 18. Additional selection criteria included being in state custody, living in a residential care facility, having a full scale IQ above 70, and having a history of psychiatric hospitalization and/or psychotropic medication use. The experiences of the seven foster youth who were stepped down from residential care are described elsewhere (Narendorf, Fedoravicius, McMillen, McNelly, & Robinson, 2011). The caseworkers, TFC service providers, and treatment foster parents, who are the focus of the present study, served the foster youth who received the pilot intervention.

Thirteen foster parents provided care for the seven foster youth participants following discharge from residential treatment. Among these foster parents, three were married with one member of the couple not employed outside the home. All but one of the three couples was African American. One of the couples cared for two foster youth participants at separate times.

Each treatment foster parent (s) was interviewed at 3 months post placement of a foster youth into a home. The interviews with treatment foster parents occurred between April 2009 and March 2010. Interviews with TFC service providers who delivered the pilot intervention (i.e. psychiatric nurse, skills coaches, program supervisors, therapist, and family consultant) took place at study completion and/or turnover in position between February 2010 and November 2010. Table 2 provides a visual layout of the foster youth participants, their treatment foster parents, and the private agency caseworkers.

The private agency caseworkers were interviewed at study completion. One caseworker supervised three of the foster youth, and two caseworkers supervised one youth each. Among the caseworkers, two were Caucasian and one was Hispanic. All were female. These caseworkers managed the case of each foster youth participant for between three and five years. Two caseworkers who served youth were not interviewed due to leaving the agency or being on leave during the time the interviews were conducted. Interviews took place between May 2009 and September 2010.

Interviews were audio taped and conducted by four trained interviewers. The interviewers were not involved in providing direct services to the foster youth. Rather, they were highly trained and experienced qualitative interviewers. The length of the interviews ranged from 60 to 75 minutes. Consistent with semi-structured interviewing, we followed a list of topics, but permitted the conversation to flow informally (Cohen & Crabtree, 2006). Questions were tailored to the respondent (i.e. treatment foster parent, caseworker, TFC service provider).

To illustrate, treatment foster parents were asked about the transition from residential care to a treatment foster home in two ways: questions about how things had been going in the home and questions tailored to the experiences of the treatment foster parent and foster youth. Thus, we asked treatment foster parents general questions (“How have things been going with ___?” “What has gone well?” “What has been the biggest challenge?”), as well as specific questions (“What has been like to parent a transition aged youth?” “What it has been like to parent a transition aged youth with mental health needs?”). The interview questions were designed to illuminate both positive and negative aspects of the step down process. Capturing and comparing multiple dimensions of an experience is a strategy commonly referred to as constant comparison (Strauss, 1987). Making these comparisons helps to describe multiple aspects of the step down process that are viewed as being important from the perspective of team members providing the intervention in the step down from residential care.

Analysis Procedures

The analyses relied on transcripts of the interviews with the treatment foster parents, service providers, and case managers. This analysis sought to identify common perceptions across stakeholders. To identify dimensions of the step down process, we used a grounded dimensional analysis, a variation on grounded theory (Kools, McCarthy, Durham, & Robrecht, 1996; Schatzman, 1991). First each line in a transcript was reviewed to identify concepts and indicators, a step that is commonly referred to as open coding in the grounded theory literature (LaRossa, 2005). This step identified conceptual labels of events in the data, resulting in a large number of concepts. In the second step, these labels were compared and grouped under a higher level category. The next step involved connecting categories and identifying the relevant contexts, strategies, and consequences of the step down process under investigation.

To illustrate, we initially coded a foster parent’s description of challenges managing moods and behaviors in the home by designating it as “extreme behaviors.” In the second stage of coding, this code was subsumed within a larger category reflecting indicators of responsiveness of foster youth to the step down from the perspective of service providers. In the third stage of coding, this concept was linked to other indicators of the transition (i.e. “developing a plan for the future” or “following young person’s lead” or “filling in gaps”) and connected to the consequence, such as the experience of “making progress” in the community. Making progress was linked to other dimensions such as “step down critical even if challenging” which entails the promising and challenging aspects of managing older foster youth with mental health conditions in the community. A team approach to analyzing the transcripts was employed. All members of the research team read the transcripts from one set of interviews. We started with the interviews with treatment foster parents, compared coded text, and discussed discrepancies until agreement was reached. Next, the process was repeated with the service provider interviews and then the caseworker interviews.

Results

Results are presented in several sections. First we describe some of the general aspects of stepping foster youth down from residential to treatment foster homes in the community and discuss the perceived importance by team members. Next, we present several dimensions of the step down process that were abstracted from the interviews through a grounded dimension analysis, including perceptions of foster youths’ engagement in the step down process; the responsiveness of service providers to transition aged foster youth with mental health conditions; and perceptions of roles in relation to the step down from residential care. Table 3 provides a conceptual model of dimensions of stepping down from the analyses.

Features of Stepping Down Older Foster Youth with Mental Health Needs

Managing serious emotions and behavioral conditions in a family setting is at the cornerstone of TFC. In contrast to a residential treatment model wherein treatment is provided within a contained setting that is designed to structure and restrict movement, TFC foster parents implement a treatment plan within a natural environment with community supports. Team members described the transition from residential settings to homes in the community as a central focus of their work, and a critical component to improving outcomes. Private agency caseworkers spoke about the long-held safety concerns in transitioning this sample of foster youth to foster homes, and the difficulty of finding foster parents willing to parent an older adolescent with extreme behavioral problems. In spite of the individual and system challenges, all of the caseworkers held hope that foster youth could be stepped down from residential settings with the right combination of supports in the community. They would talk about challenges along with the addition of positive and hopeful comments such as the following:

She had bounced around from residential to residential. She was one of those kids that people would say she can never go into a foster home. I mean there are those kids in our agency where we thought what are we going to do? I really liked that the goal was to get her out of residential with a ton of support because she was my only kiddo that I did not have a plan for. You know, I wanted a plan for her.

Stepping down older foster youth to the community after long stays in residential settings entails several general features, as demonstrated in our interviews with team members. First, the transition to a new home involves a honeymoon period when foster youth, treatment foster parents, other members of the family, and service providers get to know one another. Team members talked about foster youth as being generally agreeable, compliant, and motivated during this time, frequently offering to help out around the home without being prompted. This is also perceived of as a time in which service providers and foster youth alike become familiar with the TFC program. Second, the success of the step down hinged on the expectations that team members held for foster youth. Treatment foster parents commonly discussed the older age of the foster youth, and the ways in which their biological age did not always match their developmental functioning leading them to feel conflicted about increasing freedoms. Third, the step down was threatened when negative emotions and behaviors escalated in the home, and became a danger to safety. Rather than representing a single event, stepping foster youth down to less restrictive settings set into motion a sequence of events that centered on increasing awareness of foster youth within the context of uncertainty about the future.

Although service providers considered themselves to be experienced at working with at-risk youth, they acknowledged the substantial learning curve that comes with addressing the mental health, development, and transition needs of foster youth who had lived in restrictive care settings for long periods of time. As team members became aware of needs, a tension between moving forward and stepping back required them to go through a process of re-assessing the plan for services. This process is highlighted below by a TFC team service provider who worked directly with youth in the community:

It was a bit of trial and error at first. You know, kind of trying to figure out what doesn't work so well and what does and getting to know the individual youth to know what will work for them. I think at first I was kind of trying to rush into things like I am going to help this person to find a job right away. I realized that it takes time and you need to build up their skills and everything first before you can achieve those big goals.

Making Progress: Team Members' Perceptions of Foster Youth—As illustrated in the above quotation, one of the ways in which service providers define the quality of the step down is through perceptions of being able to assist foster youth to achieve goals. That is, it is important for team members to feel that their efforts are effective in assisting foster youth to make progress towards their independence in the community. When team members perceive progress is being made, they feel rewarded. The satisfaction that comes with assisting a foster youth to make progress in one area described below from a treatment foster parent:

She had improved so much in I guess her attitude toward others. So, it doesn't mean that she was without problems at the end of the year, but it did mean that she seemed to start to get it. And that is the type of thing you feel really good about.

Team members talked about making progress in two ways: in relation to foster youth and in relation to the TFC program. Team members discussed the progress that stemmed directly from participation in the TFC program. Prior to coming to the home a foster youth demonstrated extreme anger issues almost daily at school. These displays of anger were perceived as threatening her placement at the school and disrupting her learning. From the perspective of the treatment parents, the anger began to diminish once there was direct coordination and monitoring of behavior between the school and the treatment foster home. A private agency caseworker similarly described the ways in which being in the community provided a foster youth with a new view of herself as being competent and in control as opposed to being crazy and incapable.

The other way that the service providers talked about progress is the perceived level of engagement of foster youth in the step down. When foster youth show that they are engaged in the plan for stepping down into the community, they demonstrate their level of motivation by coming to the table with a plan, actively participating in services, and following through with suggestions offered by team members. For these team members, it was important for foster youth to be actively engaged in the step down process. However, for the majority of foster youth, active involvement in a plan for treatment and follow through was perceived of as a challenge due to the few opportunities previously provided to function independently. The challenge for a foster parent and/or service provider was therefore to facilitate the process of goal setting rather than to define goals entirely for foster youth. The team members in this study expressed the tendency to move quickly into planning for services and independence without creating the necessary space for foster youth to be genuinely involved in the process. Without genuinely involving youth in the process, plans quickly unraveled, as in the case of a treatment foster parent who enrolled a youth in community college only to discover the youth had significant delays in basic reading and writing skills. What the treatment foster parent wanted and what the foster youth could realistically accomplish became a source of tension and conflict. Following a process of trial and error with foster youth, the TFC service provider below discusses what she learned from the step down experience:

I think we need to make the youth more of a stakeholder in the process. I think we kind of make decisions for them and say this is what is entailed in the program and don't really approach it in the way that the youth would say, "Ok (to the program). I would like that and I can see where that would be useful." We just kind of force it on them.

Another way that service providers assessed the level of engagement of foster youth was through the frequency of behavioral incidents. Although the private agency caseworkers who held long-standing relationships with their clients expected foster youth to test boundaries and go through crises, treatment foster parents perceived incidents such as running away and defiance, as a sign that the youth did not want to be in the home. A

perceived feeling of rejection by foster youth was not explicitly stated, though the comment below illustrates the ways in which behavioral incidents had the potential to linger and become a threat to the placement and relationship:

I never had anybody that wanted to leave me and she ran away. So there is still that. You know, “You are in this foster home and I care for you and take care of you. But you still want to run away?” And so I mean, I don’t think that the training could have prepared me for that.

Service Providers’ Responses to Foster Youth

As service providers get to know foster youth, the meaning they make about incidents becomes a defining element in their responses to escalating emotions and behaviors. Here we discuss team members’ feelings towards foster youth and the ways in which feelings are related to responses to escalating emotions and oppositional behaviors in the home.

Positive Feelings and Responses—Team members discussed the extent to which they held positive feelings for the foster youth participants and experienced satisfaction engaging them in a relationship even through times that were challenging. When present, these aspects of positive feelings are associated with responses that open up opportunities for foster youth rather than to foreclose future possibilities, as highlighted by the comment below from a caseworker:

Because, oh my goodness! Nobody really liked her behaviors. I really loved this kid, really like her. We got along famously, but she is so dramatic and she drove people nuts – making false allegations and sabotaging plans. But you know, she was just one of those kids that you really like. I think maybe it was just the time we had together. There were times when we definitely did not get along. But then I would come back and say, “I am not going to deal with you doing this.” So, I think after so many years, there was a trust between us. That is why when I heard about this program, I thought it was perfect for her.

Positive feelings are also associated with responses to behavioral incidents that allowed service providers to preserve a relationship between foster youth and a service provider. From this perspective, a working relationship is central to de-escalating crisis situations and stabilizing foster youth in the community. The quote below from a treatment foster parent illustrates a strategy used to engage a foster youth in the step down process at a time in which the youth was on the brink of returning to residential care. Recognizing that the youth had difficulty controlling her emotions and could escalate quickly, the treatment foster parent used the moment to assist the foster youth to exercise control and decision making:

I went inside to the police department and she (foster youth) was crying saying she wanted to go back to residential treatment. And I said, what I would like for you to do is just try to calm down a little and in your mind think about the positives of what you have right now. Then think about the negatives of what you have right now. That is a way to objectively look at this so it is not your emotions that are guiding a decision that might be undoable after tonight.

Positive feelings also shift a focus away from the negative behaviors, and bring greater awareness to the relationship and establishing a trusting bond. Service providers talked about foster youth who exhibited gaps in basic skills for interacting with others, such as making simple requests of strangers, asserting needs, or exercising boundaries. Creating a trusting relationship with a foster youth allowed the service provider below to engage in conversations around issues that might have otherwise been difficult to discuss.

I think that in the beginning it (addressing behaviors) was more covert because you know I did not know them as well. We did not have as much of a relationship. As time went on, I think it was easier to directly address things because we had that bond and I knew them better. I think another important thing I learned is that we are both just two people who need to be able to interact on a basic level and it does not have to be formal all of the time.

Negative Feelings and Conflicts—At the same time that team members experienced feelings of connection with foster youth, they also reported having conflicts. Team members reported feeling manipulated by foster youth, and at times, they felt threatened. Although they perceived these responses as being related to the older age of youth, they saw the subsequent conflicts as a negative side of caring for foster youth with mental health conditions. The comments below from treatment foster parents highlight these sentiments vividly:

But I think for me it is kind of scary because we are in this room together with this child, who for me can become explosive at any time. And I think that people have avoided her becoming explosive for a long time so she is used to sending you there and then having some sort of release without ever really getting to the issue.

She keeps saying lately, “I don’t know how much longer I can do this.” So, I don’t know exactly how she means by that. I think that she has a lot of self-control, but I am afraid for the moment when she might now have it. I think she keeps creeping up on it, and then she backs down.

The hardest thing? I don’t know if there is a hardest thing. It is challenging every day because I just have to pay attention to her moods more. The hardest thing is that I have to monitor her so closely and I have to watch what I say.

As implied in the statements above, treatment foster parents struggled to make sense of mental health. They talked about walking on eggshells around youth to preserve the calm in the home. Those who tried to prevent the escalation of behaviors found that avoiding situations was effective in the short-term, but escalated emotions and behaviors if left unaddressed for too long. Areas of conflict and struggle commonly reflected foster youths’ negative reactions to limit setting, as illustrated in the quotation below from a treatment foster parent:

They were out of school and [Foster Youth] was looking at television. I said, “Instead of looking at television all day, how about tidying up your room and then come back and watch television.” Her [Foster Youth] response was, “I don’t want to live here anymore. I am ready to move.” Well, after that she figured, well we’re going to live here and not communicate. No, we are going to communicate because how do you live together and not communicate? I am not going to walk around in my own house on eggshells. What kind of control would I have if I allow you to control my house? So, you know, your clothes will not continue to be on the floor.

Perceived Role of Team Members

With complex case histories and a long list of mental health conditions, service providers described wanting to protect foster youth. They protected foster youth by limiting the scope of information that was provided to others outside of the TFC team. For example, private agency caseworkers discussed fearing that full-disclosure of long-standing histories of emotional and behavioral disorders, self-injurious behaviors, and conduct problems would become a barrier to securing a treatment foster home in the community. They talked about the ways in which certain disorders, such as bipolar and conduct disorder had the potential to scare caregivers away. Team members also talked about the ways in which they reduced

the extent of information provided to others at agency meetings in order to protect youths' right to privacy. Although enacted from a place of concern, the consequences of this dynamic are exemplified in the following quotation from a team member:

What I do know now is that we needed more psycho-education. We needed it for the youth, and we especially needed it for the foster parent. What I have read and gotten in feedback from the foster parent it is almost like they really did not know what type of youth they were getting. They were like ok I am getting a 16 year old. I am getting a 17 year old. They expected these youth would come in their home and kind of fare on their own even though they were specialized kids. These were higher end kids. They did not know that they were really severe. We talked about it in the training in terms of 'these are the types of kids' but not really an understanding the specific diagnoses. I think that would have been helpful.

When asked about the role they sought to play in the step down process, service providers responded with terms like "support" and "resource." Therefore, the ideal role relationship in the step down process is one in which the service provider provides assistance to a young person. Although providing assistance reflects the ideal, they acknowledged that services must be met with acceptance from foster youth in order to be effective. That is, foster youth must be willing to accept their mental health conditions and engage in the services recommended by professional experts. As one caseworker stated, "All the services you put in place are going to be irrelevant if the client is not willing to accept that they have a mental illness."

The statement above implies that services are critical, but only to the extent that foster youth are willing participants. Therefore, an additional role of the team members in this study is to get youth to accept the help that is being offered. Although the model of illness self-management for individuals with a mental health condition is grounded in a theory of self-determination where perceived competence for managing health and mental health behaviors is enhanced through offering individuals information and choices (Deci & Rice, 1985), the service providers in this study generally did not adopt this role purposively. Rather they grappled with their roles as professionals providing services to young adults as opposed to offering them opportunities to determine a plan for services. One occasion in which team members discussed occurred when the TFC intervention set out to educate foster youth about their mental health conditions, and assist them in planning for their future treatment needs. The team members talked about the ways in which these well-meaning efforts were not easily accepted by any of the foster youth, reflecting a powerful way in which professional or expert knowledge was imposed on the process of stepping down. In the words on one service provider:

Psycho-education, I think sometimes the kids don't want to hear it or know how to hear it. I think she (team member) did will in getting most to hear it but some did not want to participate. And she did as good as anybody trying to get them to hear could, but I just wonder how it could be presented differently to them to want to know. Because when she was talking about it, I thought, "I wouldn't want to hear all of these things about myself either."

In addition to the challenges of engaging in discussions about mental health with foster youth, service providers talked about foster youth who also voiced anger over the perceived push by team members to become adults. The push to try on social roles and engage with the tasks of young adulthood was often met with resistance, as articulated below by a treatment foster parent:

She does not want to grow up. She doesn't even want to be 17. She said, "I miss my childhood and I don't want to grow up." And then we tried to get her to apply

for a job and she is like, “I don’t want to do this. You all want me to do this. You want me to do all of these adult things. I don’t want to be an adult.” And that makes her angry. It makes her real angry.

A negative side of fostering self-determination of foster youth at the onset of adulthood is that guaranteed supports in the transition to adulthood are few in the majority of states across the country. That is, states typically discharge foster youth from the child welfare system at the age of majority (McCoy-Roth, Freundlich, & Ross, 2010). In states that have extended the age that youth may remain in foster care, these services are time-limited, typically offered to age 21. Therefore, foster youth may not have the luxury to wait to act on opportunities for work or education. That team members working with foster youth struggled to balance opportunities for empowerment with feelings to direct and control is described in the quotation below from a team member who described not wanting to be overbearing in her work with a foster youth participant:

Yeah, I would come to the table with stuff to help them and I would meet them halfway, but I also wanted them to meet me half way. I would always check in with them, but not be overbearing.

As implied above, this team member provided the foster youth participant with the valuable experience of practicing skills for self-determination and making choices within the context of a relationship. From this perspective, team members felt greater satisfaction and foster youth participants expressed less resistance when they had a say about important decisions in their life and could guide the process with intensive supports.

Discussion

This study finds that team members delivering treatment foster care describe the step down process in terms of several dimensions. The participants describe a clear sequence of events including 1) a honeymoon period when foster youth participants are agreeable and compliant; 2) an implementation period in which team members implemented plans on behalf of youth; and 3) a crisis involving an emotional or behavioral incident(s). The level of engagement of foster youth in the step down signaled to team members that the foster youth are active participants in the plan. This process was more satisfying for team members when they involved youth in the plan, provided opportunities for youth to exercise self-determination, and observed small gains in the youths’ functioning.

Service providers also perceived several negative dimensions of the step down process, such as walking on eggshells to avoid conflicts, and ongoing uncertainty about safety. Because service providers tended to view themselves as professional experts, their interactions with foster youth evoked feelings of responsibility and protection. Those service providers who developed a less formal relationship with foster youth discussed the ways in which a feeling of responsibility and/or stress was lifted when youth became actively involved in the process and they felt less pressure to make foster youth participate.

These findings extend the small but growing literature on stepping down foster youth to community-based treatments that view clients as equal decision making partners in the development of mental health treatment plans (Duchnowski, Kutash, & Friedman, 2002). Although these approaches have the broad goal of empowering clients to be in charge of their lives, the ways in which consensus is achieved between adult professionals and their clients are poorly understood. This may be particularly problematic in the case of youth and/or families who are mandated to receive services or in the case of transition aged foster youth, when youth are no longer children and yet not quite adults. The themes discussed in the current study pertain to intensive supports and protections for foster youth, but the team members did not generally formulate a consensus for treatment planning with foster youth

participants in spite of their status as young adults, who gain rights to determine the plan for services. Rather a disconnect between what foster youth wanted and what service providers were offering was discussed as related to feelings of conflict and struggle. Service providers talked about having to get foster youth to follow through with services, which produced negative judgments about foster youths' motivation and future potential. These findings suggest the community interventions for transition aged youth should broaden the definition of individualized treatment to include additional aspects concerning self-determination and decision-making. Central to a theory of self-determination is the idea that individuals are autonomously motivated when they experience volition and choice while behaving (Deci & Ryan, 1985; Ryan & Deci, 2000).

Another area to consider investigating further in future research is the honeymoon period, or the initial weeks of the placement in a less restrictive setting. Although there has been attention given to the period of the pre-placement, when the match between a youth and a caregiver is carefully assessed and attended to, our findings suggest that the initial weeks of placement may offer critical places to identify small steps made towards progress with foster youth and service providers; to tailor the treatment plan with foster youth; and to seek a consensus among team members (including foster youth) for moving forward. Providing opportunities early in the step down to experience a sense of self that is competent and in control may be particularly critical for individuals who have experienced multiple failures, losses, and disappointments.

It is important to highlight limitations of this study. First, the sample size is small and the experiences of these team members may not adequately reflect the full range of experiences of all foster parents, private agency caseworkers, or service providers in transitioning foster youth from residential to foster home settings. This may be particularly true in states that discharge foster youth from child welfare systems at the age of majority. The youth in the current study were allowed to remain in the child welfare system to the age of 21 and service provision, such as keeping youth locked up to the age of 18, may actually be quite different because youth may remain in care. Due to the nature of the pilot study, it is difficult to say whether the experiences of these team members is related to characteristics specific to foster youth, the pilot intervention, or other contextual aspects of the community. It is also possible that asking team members about negative aspects of the step down may have increased the salience of negative transactions.

In spite of these limitations, the extent to which conflicts emerged between the foster youth and service providers highlights the importance of paying attention to the feelings that are evoked between helping professionals and foster youth in the step down process. Although research on foster youth focuses attention on increasing sources of support and connections in the transition to adulthood, the ways in which helping relationships with well-meaning service providers and caregivers evoke negative responses and lead to disengagement have received far less attention in the child welfare research (Hyde & Kammerer, 2009; Kools, 1997; Samuels, 2008). Understanding the ways in which the step down process elicits feelings between foster youth and adult service providers has important implications for engaging youth in services that may offer protections in adulthood.

In summary, the findings from this study point to a need to further refine the concept of stepping down foster youth to community-based interventions. The findings show that the service providers' experience of stepping youth down has many similarities with the experiences of foster youth, at least as described in recent studies (Hyde & Kammerer, 2009; Samuels, 2009). This process is described as being complex for service providers (Freundlich & Avery, 2006; Geenen & Powers, 2007) and foster youth (Hyde & Kammerer, 2009) alike. This study shows that stepping down older foster youth to less restrictive

settings has positive and negative aspects, reflecting the interplay of distinct dimensions of long-standing dependence and emerging independence; past loss and ambiguous gains; health and mental health; awareness and uncertainty; and growth and protection. Assessments of the step down that capture the range of experiences in working with foster youth, such as feelings of rejection, uncertainty, frustration, connection and hopefulness may offer critical information early in the step down that promote the developmental competence of foster youth; the relationship that develops between helping professionals and foster youth; and prevent negative interactions from taking a toll on future possibilities.

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Highlights

- This study seeks to identify and refine the conceptualization of stepping down.
- We describe a qualitative study of treatment foster care team members.
- Dimensions of stepping down are identified through a grounded dimensional analysis.
- Findings reveal many aspects of stepping down foster youth approaching adulthood.
- Implications for further refining and measuring the concept are discussed.

Table 1

Description of Treatment Foster Care Team

Team Role	N	Description
Program Manager	3	The program manager coordinated services with the private agency, monitored service provision, provided crises services as needed, and worked with the foster parent to manage the young person's behavior in the home.
Psychotherapist	2	The therapist provided weekly, individual office based clinical services.
Skills Coach	2	The life coach organized independent living opportunities in the community based on a young person's goals such as career exploration, completing resumes, applying for jobs, and so much more.
Psychiatric Nurse	1	The psychiatric nurse reviewed the agency files and summarized case information and psychiatric history. This information was placed into a written report for the case worker, in which the diagnoses and medications were identified. A team meeting (with youth) was organized to share the information and answer questions.
Family Consultant	2	The family consultant worked with the private agency to identify relative connections and complete a permanency pact.
Foster Parents	13	The foster family provided caregiving in the home, implemented a plan for services, and coordinated services with service providers
Private Agency Caseworkers	3	The private agency caseworker was the legal guardian of the case. They facilitated case planning with the service providers.

Table 2

Foster Youth Participants and TFC Team Members

	Youth 1	Youth 2	Youth 3	Youth 4	Youth 5	Youth 6	Youth 7
	Female White	Female Hispanic	Female African American	Male African American	Female African American	Female African American	Male African American
TFH1	White Couple	African American Female	African American Couple	African American Female	African American Female	White Couple	African American Female
TFH2	-	-	African American Female	-	African American Couple	-	-
TFH3	-	-	African American Female	-	-	-	-
Case worker	1		2		3	-	-
Program Supervisor1	X	X		X	X		
Program Supervisor2/3			X			X	X
Skills Coach1	X	X	X	X	X		
Skills Coach2						X	X
Therapist1/2	X	X	X	X	X	X	X
Nurse	X	X	X	X	X	X	X
Family Consultant 1/2	X	X	X	X	X	X	X

Table 3

Conceptual Model of the Step-Down Process from Perspective of Service Providers

Perspective	Dimensions	Context	Conditions	Process	Consequences
Step down as critical experience even if challenging	1. Youths' engagement signal that they are active in the step down process.	Foster Care	<i>Facilitators</i>	Open up opportunities for learning	Progress as expected
	2. Stepping youth down is easier when youth are involved in the plan and given opportunities to inform planning.	Long Stays in Residential	Services/supports	Disrupt opportunities	Not what I expected, but some benefit
	3. Step down hinges on service providers expectations	Psychiatric Disorders	Positive feelings and Responses	Avoid opportunities for change	Frustration and Challenges
	4. Negative dimensions include escalating mental health problems and concerns about safety	Approaching 18	Youth involvement		
	5. Service providers feel responsible for protecting youth	Lack of Permanence	Blockers		
		No plan for Independence	Lack of certainty		
		Few foster homes	Perceived rejection		
			Negative responses		