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Foster Youth Transition to Adulthood: Effects of Housing Stability and Social Support on Mental Health

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Abstract

Foster care adolescents have a more difficult time transitioning to adulthood, compared to non-foster care peers, due to the maltreatment and uprooting they often experience prior to entering the foster care system. Although foster care protects children from harmful environments, literature supports that multiple placement changes and lack of stable family and social support contributes to higher likelihood of housing instability, such as homelessness, and mental health problems, including stress, anxiety, and depression, in adulthood. Independent living programs, such as YVLifeSet, facilitate more successful transitions to adulthood by offering support in the form of mentors, life-skills training, and counseling. These programs improve foster adolescents’ self-efficacy with practical and emotional tools for more likely success in adulthood. Using secondary data from MDRC’s one year evaluation of Youth Village’s foster youth, the current study determined social support, including familial closeness, and housing stability correlate negatively with mental health problems. Regressions identified familial closeness and housing stability as predictors of better mental health. Independent t tests confirmed participation in independent living programs (YVLifeSet) produced significantly better mental health and housing stability after exiting foster care, compared to non-participants. The study findings demonstrate the significant difference independent living programs, like YVLifeSet, can make on foster youths’ mental health by increasing their sense of support and stability.

Keywords: foster care adolescents, transition to adulthood, self-efficacy, social support, housing stability, placement stability, mental health
Introduction

Of the 70,000 foster adolescents leaving the United States foster care system each year, many experience difficulties transitioning from foster care to independent adulthood because of traumatic experiences combined with poor access to health care. When the government discovers children suffer from abuse or neglect, the children are removed them the harmful situation and placed in relative homes (24%), nonrelative foster homes (53%), institutions, group homes, or preadoptive homes (Gypen, Vanderfaeillie, De Maeyer, Belenger, & Van Holen, 2017). Although removal from dangerous familial homes provides protection, placement in unfamiliar environments followed by frequent housing changes leads to instability due to a lack of structure and changing routines, including moving schools, separation from friends and siblings, and losing contact with parents. Separation from home followed by placement in unpredictable environments is difficult for children in general, but it is especially difficult when merged with experiences of abuse and neglect. Relationships exist between exposure to trauma in childhood and long-term health needs, making foster youth especially vulnerable, and can lead to lack of social support, psychosocial issues such as mental health and substance abuse problems, limited work experience, lower education levels, exposure to crime and violence, residential segregation, and language and literacy barriers (Manno, Jacobs, Alson, & Skemer, 2014; United States Department of Health and Human Services, 2014).

Almost 80% of foster youth have significant physical, developmental, and mental health care needs, and after leaving the system 30% report having serious health problems and 32% report the inability to obtain health care services (Deutsch & Fortin, 2015). Independent living programs were created in an effort to ease young adults’ transition from foster care to adulthood, and they aim to alleviate the instability foster youth experience by providing support through
counseling, education, financial aid, and emphasis on obtaining a high school diploma. The government allots resources and funding to foster adolescents transitioning to adulthood; yet, independent living programs need strong program evaluation data to demonstrate effectiveness and to provide direction for allocation of the limited resources they receive. Youth Villages, a nonprofit social service organization serving behaviorally and emotionally distressed children and their families, created an independent living intervention for foster adolescents, titled YVLifeSet. Evaluation of YVLifeSet found the program’s participants had increased earnings, housing stability, economic well-being, and mental health, compared to a group that did not receive independent living services (Valentine et al., 2015).

**Problem Statement**

Many foster youth are likely to have mental health problems, but there is a gap in the literature on the correlations between specific foster youth’s experiences impacting mental health. Although YVLifeSet participants demonstrated improvement in mental health, the specific interventions that impacted mental health are unknown. Discovering the relationships between social support, housing stability, placement stability, and mental health can improve outcomes by detecting which foster care experiences decrease the possibility of mental health problems. Independent living programs can then dedicate resources to the most impactful variables and apply the correlations by modifying curriculum to better assist foster youth.

**Purpose**

The purpose of this project was to determine the impact social support, placement stability, and housing stability have on mental health outcomes in foster youth by evaluating outcomes in Youth Village’s foster care alumni. Additionally, the project aimed to increase support for Youth Village’s by confirming the impact YVLifeSet has on housing stability and mental health. Three
hypotheses were tested to determine these variables’ influence on mental health. Hypothesis one assumed placement stability, housing stability, and social support correlate with mental health. Hypothesis two postulated housing stability and social support predict better mental health. Hypothesis three aimed to confirm foster youth participating in YVLifeSet have better mental health and housing outcomes, compared to the control group that did not receive independent living services.

**Review of Evidence**

**Background**

The American Academy of Pediatrics designated foster care children and adolescents as having special health care needs (Deutsch & Fortin, 2015). In 2014, there were 415,129 children in the US foster care system, and 35% to 50% in child welfare systems suffer from health disparities (Child Welfare Information Gateway, 2016; Deutsch & Fortin, 2015). Foster care protects children from the neglect, and physical, sexual, and emotional abuse caused by parents or primary caregivers (Child Welfare Information Gateway, 2013; United States Department of Health, & Human Services, Administration for Children and Families, 2016). Within 12 months of entering foster care, a permanency court hearing takes place to establish permanent plans for children, encouraging reconnection with family or placement in adoptive homes. However, 34% of children ages 12-20, exit the system without achieving permanency (United States Department of Health, & Human Services, Administration for Children and Families, 2016). During the ages of 12-20, valuable cognitive development occurs as youth begin transitioning into adulthood. Promoting successful transitions out of the foster system by providing increased support during this life period can increase their outcomes and success living independently.

Despite foster adolescents’ need for support, when they age out of system at the age of
18, their access to housing, education, and mental health counseling decreases significantly (Gypen et al., 2017; Keller, Cusick, & Courtney, 2010). Negative social determinants of health, such as discrimination and racism, lack of available resources to meet daily needs, and lack of social security and stable housing negatively affect the outcomes of foster youth (United States Department of Health and Human Services, 2014). Non-foster youth often continue to receive financial and social support from their guardian after turning 18 and gradually progress to independence. Contrarily, foster youth often lack preparation and support from adult communities that non-foster youth receive, making transitioning to adulthood more difficult for this population (Brown, Courtney, & McMillen, 2015; Manno et al., 2014; Valentine et al., 2015). Due to the inadequate preparation for transition out of foster care, some of these adolescents are eventually homeless, victimized, or incarcerated.

In the past decade, the government made efforts to improve education and preparation for foster care youth’s independence. The 2008 Fostering Connections to Success and Increasing Adoptions Act provided federal funding for states choosing to support foster youth past the age of 18, if the youth are students or employed (Manno et al., 2014). Healthcare legislation in 2014 improved care access by extending Medicaid eligibility to all former foster care youth until their 26th birthdays (Brown et al., 2015). Although the government attempts to provide more support and financial assistance, foster care organizations still lack sufficient funding and lack evidence-based research supporting interventions to improve youth’s transitions to adulthood (Hudson, 2013; Singer & Berzin, 2015; Stott, 2013). Literature portrays increasing support by intervening in the areas of mental health, social support, and housing stability significantly impacts foster youth’s success as independents.
Mental Health Needs

One-half to two-thirds of foster youth meet the criteria for a mental health diagnosis with high rates of post-traumatic stress disorder, reactive attachment disorder, and depression (Ahmann & Dokken, 2017; Brown et al., 2015; Gypen et al., 2017). Although an average of half of foster care adolescents access behavioral healthcare services within 12 months before leaving the system, their access to these services decreases by over 50% in the year following their exit (Brown et al., 2015; Gypen et al., 2017). Lacking sufficient behavioral health support in the community makes it difficult to find adequate placements for youth with mental health needs, requiring youth change housing placements based on the level of mental health care they require (Stott, 2013). The behavioral issues often combined with mental health problems also increase the chance for placement instability, as foster parents request the child to be assigned to a different home. Because foster care adolescents utilize significantly more behavioral healthcare services than their non-foster care peers, independent living interventions include mental and behavioral health support and counseling (Brown et al., 2015). In efforts to support interventions, studies evaluate mental health needs and outcomes by assessing for anxiety disorders, depressive symptoms, posttraumatic stress symptoms, substance use disorders, antisocial behavior, and chronic stress, finding significantly improved mental health outcomes in adolescents receiving independent living services (Brown et al., 2015; Kessler et al., 2008; Valentine et al., 2015).

Placement and Housing Stability Needs

Placement and housing instability increase the risk of behavioral problems in foster youth during and after their time in the system (Rubin, O'Reilly, Luan, & Localio, 2007). Placement instability refers to multiple placement changes while in foster care, and housing instability describes difficulties foster youth alumni encounter when attempting to establish housing after
Exiting the system. Frequent placement changes prevent youth from continuing relationships with educators, families, friends, and mentors, making it difficult to form lasting connections with people outside of the foster care system and can result in poorer functioning in adulthood (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Curry & Abrams, 2015; Stott, 2011). Evaluations measure placement instability by reporting how many different placements youth experienced since entering the system (Keller et al., 2010; Valentine et al., 2015). A landmark study examining housing variables found higher rates of problem behaviors, including expulsion from school or jail time, in participants with more than five placements, with histories of running away from a placement, or with nonfamily arrangements (Keller et al., 2010). In comparison, a group living in family placements reported better outcomes and higher levels of grade retention (Keller et al., 2010).

Attempting to increase housing stability, the Chafee Act extended support for foster youth until age 21, allowing states to use up to 30% of funding for room and board; however, this contribution has been unsuccessful in improving access to safe housing (Curry & Abrams, 2015; Stott, 2013). An average of 30% of former foster youth experienced homelessness or lived in five or more places since exiting the system because of the inability to pay rent, poor credit scores, or the absence of a supportive co-signer for lease agreements (Curry & Abrams, 2015; Gypen et al., 2017; Stott, 2013). Stable and supportive relationships with peers and adults while in the system, increases networks of support when they age out of the system, increasing chances for finding stable housing (Curry & Abrams, 2015). For example, programs like YVLifeSet revealed the provision of specialists to offer financial assistance and aid with tasks, such as finding a home, improved housing stability outcomes (Curry & Abrams, 2015; Valentine et al., 2015).
Social Support Needs

Social support improves outcomes for foster youth, including reduction in depressive symptoms and perceptions of stress (Munson & Mcmillen, 2009; Salazar, Keller, & Courtney, 2011). Separation from family, placement instability, and deficient role models contribute to decreased support in this population (Greeson, Garcia, Kim, Courtney, 2015a; Greeson, Garcia, Kim, Thompson, Courtney, 2015b; Valentine et al., 2015). Independent living programs aim to establish a social support network with mentoring and counseling to combat the stress associated with aging out of foster care (Donkoh, Underhill, & Montgomery, 2009; Pecora et al., 2006; Salazar, Roe, Ullrich, & Haggerty, 2016; Valentine et al., 2015).

One study found social support decreased at an exponential rate among foster youth employed at baseline, which was interpreted as a negative interaction effect because employed youth started out with higher support at baseline (Greeson, et al., 2015a). Additionally, social support showed a more significant impact in youth who experienced fewer types of maltreatment, as opposed to more complex abuse histories (Salazar et al., 2011). However, there is inadequate data showing independent living interventions increase foster youth’s perceptions of social support (Greeson et al., 2015a; Greeson et al., 2015b; Valentine et al., 2015). Studies measure social support by asking fostered youth how many people they could turn to for help and by determining the youth’s perception of closeness to nonfamilial and familial adults (Greeson et al., 2015a; Greeson et al., 2015b; Valentine et al., 2015). Evaluating perceptions of support is a complex process and a subjective measure which increases the risk for insignificant results.

Discussion

Histories of maltreatment, placement and housing instability, and inadequate social and
mental health support lead foster care adolescents’ difficult transitions to adulthood (Brown et al., 2015; Keller et al., 2010; Mersky & Janczewski, 2013). Literature confirms improvements need to be made to better care for foster youth during their transition to adulthood by helping them to establish stable environments, encouraging educational achievement and employment, providing behavioral services, and promoting health maintenance (Mersky & Janczewski, 2013; Stott, 2013). Independent living programs like YVLifeSet offer stable environments with positive role models who assist adolescents in setting goals, increasing their sense of self-efficacy and improving outcomes in economic wellbeing and mental health (Valentine et al., 2015).

**Theoretical Model**

This scholarly project uses Albert Bandura’s social cognitive theory as the framework and specifically focuses on self-efficacy’s influence on foster care adolescents’ outcomes. By creating the social cognitive theory and defining self-efficacy in the 1970s, Bandura (1977a) introduced an alternative philosophy for the process of psychological change. In his work, Bandura hypothesized perceptions of self-efficacy influence people’s coping behaviors, the amount of effort they expend, and their perseverance when facing adverse experiences (Bandura, 1977a). Bandura continues to expand on the concept of self-efficacy, remaining relevant in current society by applying his concepts to new populations. Literature supports Bandura’s theory appropriately applies to foster care adolescents by describing the impact homelessness, social rejection, violence exposure, juvenile justice custody, and foster care placements have on the formation of self-efficacy (Bandura, 2006; Bradshaw, Goldweber, & Garbarino, 2013; Carroll, Gordon, Haynes, & Houghton, 2013; Dooley & Schreckhise, 2013; Maccio & Schuler, 2012).
Concepts of Self-Efficacy and Familial Self-Efficacy

The social cognitive theory proposes human functioning results from communication between a person’s cognition, emotions, behaviors, and contextual variables, such as changing environmental conditions (Bandura, 1977a; Bandura, 2006; Schunk & Meece, 2006). Bandura (1995) defined self-efficacy as people’s beliefs about their ability to influence events in their lives, referring to a person’s self-esteem and sense of power and control over their circumstances (Bandura, 1995; Maccio, & Schuler, 2012). Conversely, low self-efficacy is a person’s belief they lack the power to successfully complete tasks or achieve goals (Maccio & Schuler, 2012).

The concept of familial self-efficacy recognizes the strong impact social environment has on behaviors, including parents’ or caregivers’ contribution to children’s competence by providing positive role models who teach independence and perseverance (Bandura, 1977b; Bradshaw et al., 2013; Caprara et al., 2006; Schunk & Meece, 2006). This form of a secure parental relationship gives youth the ability to pursue their personal values and freedom. Influential self-efficacy development typically takes place during children’s transition to adulthood and depends on motivation and influence from family and other community members (Bandura, 2006; Caprara et al., 2006; Schunk & Meece, 2006).

Assumptions

Bandura (2006) assumes adolescence is a critical developmental period when youth begin to form a sense of personal identity and agency over their circumstances. Their sense of self-efficacy develops as they exert control in their lives by setting goals, self-organizing, and self-regulating (Bandura, 2006; Carroll et al., 2013). Adolescents formulate ideas of how behaviors influence outcomes and discover what behaviors are appropriate by observing others in their environment, such as family members (Bandura, 1995; Bandura, 2006). Because adolescent’s
own self-efficacy is not enough to ensure attainment of their goals, their self-efficacy must come from a combination of their own experiences and from the experiences of the people surrounding them. Therefore, by sharing knowledge and responsibility with family and other role models, through connections with others, and from mutual obligations, adolescents shape a stronger self-efficacy (Bandura, 2006; Caprara et al., 2006).

In addition to observation, the social cognitive theory assumes behaviors are further refined by informative feedback (Bandura, 1995). Bandura (1977a) suggests four key sources contribute to a person’s self-efficacy by providing constructive encounters. These sources include performance accomplishments, vicarious experiences, verbal or social persuasion, and physiological or somatic emotional states (Bandura, 1977a). Furthermore, he believes people must have faith in their efficacy and worth, for self-development, successful adaption, and change to occur, suggesting when adolescents perceive self-efficacy they will cope better as adults because they believe they are capable (Bandura, 1995; Bandura, 2006).

**Application to Project**

A strong social support system, including factors of familial, social, and housing stability contributes to self-efficacy development; yet, foster youth frequently lack support networks, suggesting this population has more difficulty developing strong self-efficacies than other adolescents (Bandura 2006; Caprara et al., 2006; Carroll et al., 2013; Schunk & Meece, 2006). Deficient development of self-efficacy affects the characteristics and coping capability of adolescents’ emotional life, increasing their vulnerability to stress and depression (Bandura, 2006). Because much of the discovery and feedback influencing self-efficacy occurs during the formative years prior to exiting foster care, the environment and social influences surrounding them during the time before independence can significantly impact the development of their
behavior and self-efficacy in adulthood (Bandura, 2006; Caprara et al., 2006; Carroll et al., 2013; Schunk & Meece, 2006). Empowering adolescents in decisions about their education and housing, as encouraged by programs like YVLifeSet, increases senses of self-efficacy and engagement in future planning, improving foster youth’s social, mental health, and housing circumstances as adults (Dooley & Schreckhise, 2013; Stott, 2013; Valentine et al., 2015).

Bandura’s theory contributes to the foundation of this project by describing the impact housing and social support have on self-efficacy, and in turn housing, social support, and self-efficacy’s influence on mental health. By applying the variables of mental health, housing and placement stability, and social support to Bandura’s cognitive, environment, and social concepts, Figure 1 demonstrates how the variables in this scholarly project influence self-efficacy, and in turn this population’s outcomes in adulthood. Similar to Bandura’s original model, Figure 1 assumes social, environmental and cognitive factors are connected and interrelated in developing a strong self-efficacy (Bandura, 1978). Additionally, this figure elaborates on the types of interventions programs, like YVLifeSet, to improve social, cognitive, and environmental outcomes by increasing self-efficacy in foster youth.

**Project Design**

Review of evidence and theory implies housing stability, placement stability, and social support encourage development of self-efficacy, impacting mental health. To explore these connections, this scholarly project utilized a secondary data analysis design with de-identified secondary data from MDRC’s one-year impact evaluation of Youth Village’s Transitional Living program. MDRC is a nonprofit educational and social policy research organization. The analysis design explored connections between the three variables of housing stability, placement stability, and social support and the impact they have on mental health outcomes. Additionally, the project
used a quasi-experimental design to confirm the impact YVLifeSet has on housing stability by comparing randomly assigned control and intervention groups in the secondary analysis of data. The data’s original study design was an independent evaluation conducted by MDRC of the YVLifeSet program and used random assignment to treatment or control groups (Valentine, Skemer, & Courtney, 2015). Participants enrolled in the evaluation between October 2010 and October 2012. The primary source of outcome data was a survey fielded one year after study entry. The data used for this scholarly project was originally collected between October 2011 and December 2013 and then de-identified for patient protection. Institutional Review Board approval was granted at the time of the original study and for the current project. This scholarly project data analysis occurred from October 2017 to March 2018.

Practice Setting

This scholarly project did not have an intervention or collect primary data so there was not a practice setting. Data analysis occurred at Belmont University and at the home of the project leader. The original study’s data collection occurred in Tennessee at Youth Villages. MDRC evaluated this organization’s YVLifeSet program, which provides independent living interventions to foster care and juvenile justice custody youth by teaching skills to aid in their transition to adulthood. Each year Youth Villages serves over 22,000 children and their families nationwide, including youth with emotional and behavioral disorders, substance abuse, and those who have suffered maltreatment, such as physical and sexual abuse. Additionally, Youth Villages engages in continual program evaluation and alumni outcomes review to ensure their programs are effective and evidence-based.

Accessible Project Population

The scholarly project analyzed only de-identified data from MDRC’s dataset from the
one-year impact findings and included data from both the control and the program groups (n=1,322). The project population consists of adolescents ages 18 to 24, living across the state of Tennessee with a DCS custody history, including foster care or juvenile justice custody.

Participants were required to have been in custody for at least 365 days after the age of 14 or for at least one day after the age of 17. To obtain their data, MDRC conducted a randomized control trial and assigned 1,322 young people enrolled in the evaluation into a program group (n=788) or a control group (n=534). The program group was offered Transitional Living program services through YVLifeSet, such as intensive case management, support, and counseling. The control group was not offered Transitional Living program services, but instead was offered a list of other social service resources available in the community. The survey data was completed by 1,114 of the 1,322 sample members, and includes information about service receipt, school enrollment and educational attainment, employment and earnings, housing stability, economic well-being, social support, health and safety, and criminal involvement.

Exclusion criteria for participants in MDRC’s original study included being less than 18 years old within study enrollment time frame, being over age 24, having previously received Transitional Living services, and failing to meet state custody eligibility requirements. Additionally, participants were excluded if they had a history of life-threatening violence or criminal involvement, severe substance abuse issues, ongoing mental health problems, intense emotional problems, or developmental delays.

**Sources of Data/ Instruments/Measurements**

MDRC used four tools to analyze the responses used in this scholarly project, including a housing instability scale, mental health scale, social support scale, and familial closeness scale. Housing stability scores were based on the housing instability scale, which is the sum of
responses to four survey questions developed by MDRC. Questions ask whether a participant experienced homelessness, couch-surfed, was unable to pay rent, or lost housing because of an inability to pay rent. The scale ranges from zero to four depending on the sum of responses to four survey questions. For the purpose of this project, higher levels of housing stability were defined as a score of zero, meaning they responded no to all questions.

This project based social support and familial closeness scores on scales developed by MDRC, which are the mean of responses to survey questions asked one year after entering their study. The first set of social support questions refer to the number of people a participant can count on for various types of support, including invitations to go out and do things, help with budgeting or money problems, advice about important subjects, help with transportation, listening to problems, granting small favors, and providing monetary loans in the event of an emergency. This scale ranges from 0 to 99. MDRC developed a familial closeness scale to provide a secondary measure of social support. The second scale was based on response to six survey questions asking how close a sample member feels to certain family members. Responses were recorded on an ordinal scale and a sum was produced using the six values. The familial closeness scale measuring social support ranges from 0 to 18.

Additionally, scores for mental health problems were based on a 21-question Depression Anxiety Stress Scale (DASS-21), which measures symptoms of depression, anxiety, and stress. The scale includes questions regarding how often a person has felt a certain way, ranging from none of the time to most of the time. Responses were given on an ordinal scale and a sum was produced using the 21 values. The continuous scale ranges from 0-63. The Dass-21 has been used in foster care populations by MDRC (Valentine et al., 2015). Additionally, DASS-21 has been tested by evaluators for specificity and reliability (Osman et al., 2012). Overall, depression,
anxiety, and stress scales all had reliability greater than 0.80. For depression, Cronbach alpha (\(\alpha\)) was 0.85, for anxiety \(\alpha\) was 0.81, and for stress \(\alpha\) was 0.88 (Osman et al., 2012). Additionally, because Cronbach alpha has been found to underestimate internal consistency reliability in multidimensional instruments, the study also utilized the McDonald coefficient-omega (coefficient-\(\omega\)) (Osman et al., 2012). For depression scale, coefficient-\(\omega\) was 0.86, for anxiety coefficient-\(\omega\) was 0.82, and for stress coefficient-\(\omega\) was 0.88 (Osman et al., 2012).

Placement stability was based on baseline data from a questionnaire completed by participants prior to beginning in the study. Responses to the number of placements were measured in the original study by ordinal values with three levels, one, two to five, six to ten, and more than ten. This project defined lower levels of placement stability as having more than five placements. Literature supports multiple placements are related to instability and negative outcomes, such as increased incidence of behavioral and mental health problems (Keller, Cusick, & Courtney, 2007; Koh, Rolock, Cross, & Eblen-Manning, 2014; Leathers, 2006; Newton, Litrownik, & Landsverk, 2000; Valentine et al., 2015). Many studies defined more than three placements as failure; however, because the ordinal values in the current dataset used two to five as a category, instability will be more clearly defined as more than five placements. Furthermore, a meta-analysis found 10 additional studies that utilized number of placements as indicators of placement failure (Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007). For additional information on the survey tools used, see appendix A.

After gaining IRB approval, Youth Villages sent the project leader a protected Excel file with the de-identified dataset. The dataset and SPSS data were kept in a password protected file on a password protected computer. The project leader was the only person with access to the passwords.
Results

IBM SPSS 24.0 statistical analysis software was used to perform statistical analysis, including descriptive analysis, $\chi^2$, correlations, linear regression, and independent t test (IBM Corp, 2015). Normality was assessed using the Shapiro-Wilk test, which indicated that placement stability, housing stability, mental health, familial closeness, and social support are not normally distributed (Shapiro & Wilk, 1965). While these measures do not display normality in all groups, based on inspection of the data visually on plots and charts, as well as, evaluating the large sample size, it was determined that parametric methods were appropriate (Hair, Black, Babin, Anderson, & Tatham, 2006; Lumley, Diehr, Emerson, & Chen, 2002). Point-Biserial Correlation are appropriate for evaluating the linear correlations (Tate, 1954; Tate, 1955).

A Post hoc power analysis $\alpha = 0.05$, n (455,659) for the mental health t test, determined this test to have a power = 0.91 to detect an effect size of 0.2. Post hoc power analysis $\alpha = 0.05$, n (454,657) for the housing stability t test, determined this test to have a power = 0.91 to detect an effect size of 0.2 (Erdfelder, Faul, & Buchner, 1996). One subject in the treatment groups was removed due to outlier analysis.

Descriptive statistics for the sample, YVLifeSet, and control groups are presented with group difference statistics (Table 1). The age participants were placed in state custody was the only significant demographic. Thirty two percent of the participants were 15 or 16 years old when first placed in state custody, and 60.4% of the participants were placed in custody due to neglect. Additionally, 50.8% of participants reported receiving psychological or emotional counseling in the past year.
Findings

Correlations were run to assess the association for placement stability, housing stability, social support, and familial closeness with mental health. Pearson’s correlation coefficient was computed for social support and familial closeness. Point-biserial correlations were computed for placement stability and housing stability. Results indicated that familial closeness ($r = -.112$), social support ($r = -.096$), and housing stability ($r = -.306$) were significantly negatively correlated with mental health. (See Table 2)

A linear regression model was constructed and executed to assess the impact of housing stability and familial closeness on mental health. Results indicated a significant relationship $[F(2, 1108) = 59.48, p<0.001]$ with a R squared of .095. As hypothesized, familial closeness ($\beta = -.059, p = 0.043$) and housing stability ($\beta = -.295, p<0.001$) are significant predictors of mental health. All VIF statistics were below 2. (See Table 3)

An independent samples t-test was conducted to determine that YVLifeSet participants have better mental health and housing outcomes, compared to the control group that did not receive independent living services. Levene’s test indicated homogeneity for mental health $F(455, 659) = 3.54, P = 0.06$ and heterogeneity for housing stability $F(454, 657) = 6.75, P = 0.01$. There was a significant difference in the mental health scores for the YVLifeSet group ($M=9.83, SD=10.02$) and the control group ($M=11.13 SD=10.91$) conditions; $t (1112)=2.06, p = 0.04; d=-0.125$. There was a significant difference in housing stability scores for the YVLifeSet group ($M=.99 SD=1.24$) and the control group ($M=1.18 SD=1.32$) conditions; $t (931.82)=2.46, p = 0.01; d=-0.152$. These results suggest that mental health and housing stability are significantly different between the YVLifeSet and control groups, supporting the project’s hypothesis.
Discussion

The study aimed to reveal factors influencing foster care youth’s transition to adulthood. Specifically, the purpose of the study was to determine the impact placement instability, housing instability, and social support have on mental health outcomes in foster alumni, one year after participating in MDRC’s evaluation. By exploring relationships between these four variables, the study discovered correlations and predictors of mental health in foster care adolescents.

Correlations with Mental Health

The first hypothesis predicted placement stability, housing stability, and social support negatively correlate with mental health problems. After statistical analysis, the results confirm a negative correlation between housing stability and social support, including familial closeness, with mental health scores. As housing stability, social support, and familial closeness increase, mental health problems scores on the DASS-21 decrease. These results are consistent with previous studies’ findings on the effects stable housing and social support have on mental health (Curry & Abrams, 2015; Munson & Mcmillen, 2009; Salazar et al., 2011; Stott, 2011; Stott, 2013). For example, Salazar et al. (2011) found social support decreased depressive symptoms, and additional studies discussed the adverse consequences of homelessness (Curry & Abrams, 2015; Munson & Mcmillen, 2009; Stott, 2011; Stott, 2013).

There was not a significant correlation found between placement stability and mental health in the current analysis. This finding agrees with the literature, as there are no studies showing placement stability alone correlates with mental health, measured as depression, stress, or anxiety. However, studies have found multiple placement changes correlate with behavior problems, especially when placement changes coincided with nonfamilial placements (Keller et al., 2010; Rubin et al., 2007). Additional studies support the negative impact placement
instability has on foster care adolescents’ social support systems (Courtney et al., 2001; Curry & Abrams, 2015; Stott, 2011). Based on this study’s findings and the literature, social and family connections may be stronger predictors of mental outcomes than placement changes. These conclusions continue to support the theory of self-efficacy and the importance of social and environmental influences in adolescence (Bandura, 2006).

**Predictors of Mental Health**

As postulated in hypothesis two, housing stability and social support are predictors of better mental health. Regressions revealed housing stability and familial closeness, a secondary measure of social support, significantly decrease mental health behaviors. Discovering these variables are predictors of mental health strengthens current literature’s findings on the importance of secure housing and social support in this population. As mentioned in previous studies, the inability to obtain permanent housing often results in homelessness in this population because they lack a family or childhood home from which to return (Curry & Abrams, 2015; Stott, 2013; Valentine et al., 2015). This study validates Bandura’s beliefs that having an increased sense of self-efficacy and control over one’s circumstances, exemplified as secure housing, contributes to better mental health (Bandura, 1977a; Bandura, 2006). As the theory of self-efficacy portrays, familial support produces confidence which increases the likelihood of goal attainment, such as securing stable housing, creating a successful transition to adulthood.

**Impact of YVLifeSet**

Hypothesis three expected to confirm MDRC’s findings that foster youth participating in YVLifeSet have better mental health and housing outcomes, compared to the control group which did not receive independent living services. The statistical analysis found significant differences in mental health and housing stability between the two groups, verifying foster youth
in YVLifeSet have better outcomes. In addition to housing and mental health, MDRC found YVLifeSet increased economic well-being and earnings for participants (Valentine et al., 2015). Previous studies evaluating the effects of programs similar to YVLifeSet did not find significant differences, making MDRC’s and the current study valuable to strengthen support for independent living programs (Courtney et al., 2001; Greeson et al., 2015a; Greeson et al., 2015b; Valentine et al., 2015).

YVLifeSet’s impact on housing stability is especially notable because participants were not provided access to housing or financial support for being in the program (Valentine et al., 2015). Valentine et al. (2015) hypothesized the difference in housing between the groups existed due to the life skills counseling participants received from program mentors. The mentors were trained in evidence-based cognitive behavioral interventions which could have aided in fostering stronger self-efficacy in participants (Valentine et al., 2015). Although the effect of nonfamilial social support on foster youth rarely demonstrates statistical significance, Valentine’s et al. (2015) discussion of mentor influence offers support for the positive impact social support has on foster youth outcomes.

**Implications for Practice**

There are multiple remaining ways to examine the variables in this study and how they correlate to outcomes in this population. For example, although placement stability and social support were not predictors of mental health directly, it would be informative to discover if placement stability while in the system is a predictor of housing stability after exiting the system. Because this study and many others have found social support difficult to measure, developing a tool to accurately measure social support would be valuable. Additionally, including more variables, such as income, to determine if financial stability is as significant as family and
housing in mental health would aid to encourage government officials to allocate more funds to
foster care programs for assistance after youth leave the system.

Findings from this study highlight the importance of environmental factors, such as
housing, and the social systems surrounding foster care adolescents during their transition to
adulthood, and the impact those variables can have on their mental health. This study supports
the idea that perceptions of family closeness improve outcomes, even when stable housing is not
a factor. Ultimately, the theme of stability, whether it is in the form of fewer placement changes,
stable housing, or a sense of family, improves circumstances. Programs should emphasize the
incorporation of social support and provide secure family-like connections. In terms of support,
professionals who come in direct contact with this population should encourage adolescents to
set goals and increase self-efficacy, educate them with skills to apply for housing, and support
them in finding employment to pay for housing. Independent living services like YVLifeSet need
further assistance to improve youths’ transitions to adulthood by providing secure environments
for education and counseling.

**Strengths and Limitations of the Study**

This study examined a large sample, including both females and males of multiple races,
ethnicities, and backgrounds. Although not a national sample, it represents youth from both
suburban and rural communities. The sample size and characteristics make this study
generalizable and transferable. However, when discussing mental health outcomes, it must be
considered that youth with a history of serious violence or intense emotional problems were
excluded from the sample.

Some limitations exist in the tools used for the study. The social support, familial
closeness, placement instability, and housing instability scale do not have a cronbach alpha;
however, tools using similar survey questions have been cited throughout the literature. Furthermore, the variables used as an indicator for placement instability and housing stability are simple dichotomous items based on responses to single survey questions. Placement stability was deemed an important concept to measure based on the literature and consultation with experts in foster care; yet, it is important to acknowledge the limitation of using only one question to measure the variable. Although the tool used to assess placement instability may have been one cause for the lack of significance found, it is also important to note 63.5% of the participants in the study entered foster care after the age of 14. Placement changes may have been more significant in a sample where the participants entered care at earlier ages, making it more likely for them to experience multiple placement changes throughout the course of their childhood.

It was surprising to discover familial closeness predicted mental health, while social support was insignificant. Lack of significance when evaluating social support is a common theme in the literature (Courtney et al., 2001; Greeson et al., 2015a; Greeson et al., 2015b; Valentine et al., 2015). Barriers to measuring perceived social support, such as personal definitions or interpretations of support, make it difficult for data to show improved outcomes are achieved through interventions like YVLifeSet. Therefore, using a familial closeness scale strengthens this study’s comprehensive evaluation of social support by including perceptions of family relationships.

**Conclusion**

Entering adulthood is a stressful and uncertain time for all adolescents, but particularly for those exiting foster care who may not have a family or community to depend on for support. The current study found familial closeness and housing stability to be predictors of better mental health in foster care adolescents. Additionally, familial closeness, social support, and housing
stability were statistically correlated with mental health. By examining the influence housing and support have on foster care adolescents during their transition to adulthood, the study supports the value of independent living programs like YVLifeSet to increase stability during this difficult transition. This study further increases evidence that Youth Villages and similar programs are making significant changes in the lives of vulnerable foster youth. Offering data on the influence of housing and support motivates programs to continue strengthening these curriculum areas and demonstrates the need for continued and additional funding of independent living programs. Increased access to independent living programs, housing, and mentors can positively influence foster youths’ achievement of stability and safety in adulthood.

Acknowledgments

This research uses data that were collected by MDRC for the Youth Villages Transitional Living Evaluation. The authors thank MDRC for access to the data. The conclusions and opinions stated in this paper are those of the authors and do not necessarily reflect those of MDRC. The study would not have been possible without Youth Villages support.

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Figure 1: Applying Social Support, Mental Health, and Housing Stability to Bandura’s Self-Efficacy Model

Social Influences/Social Support
- Lack of familial support
- Strained parental relationships
- Lack of role models

Cognitive Influences/Mental Health
- Chronic stress
- Depression
- Anxiety

Environmental Influences/Housing and Placement
- Violence exposure
- Foster care system
- Poverty
- Multiple placements

YVLifeSet Curriculum
- Evidence-based tools
  - Personal care
  - Healthcare
  - Social skills safety
  - Job seeking skills
  - Housing
  - Money, home, and food management
  - Behavior treatment for alcohol and other substance abuse
- Weekly meetings with transitional living specialist
  - Counseling
  - Development of goals
  - Cognitive behavioral therapies

Need for intervention

Increased self-efficacy

Goal attainment

Social Outcomes
- Increased number of people in support system

Cognitive Outcomes
- Improved mental health measured by:
  - Depression, anxiety, stress

Environmental Outcomes
- Increased earnings
- Increased housing stability
- Increased economic well-being
### Table 1: Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Sample</th>
<th>YVLifeSet</th>
<th>Control</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>1322(100.0)</td>
<td>788(59.6)</td>
<td>534(40.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Age placed in custody</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤5 years</td>
<td>85(6.4)</td>
<td>58(7.4)</td>
<td>27(5.1)</td>
<td>$\chi^2(4) = 11.89; p=0.018$</td>
</tr>
<tr>
<td>&gt; 5 ≤ 10 years</td>
<td>83(6.3)</td>
<td>53(6.7)</td>
<td>30(5.6)</td>
<td></td>
</tr>
<tr>
<td>&gt; 10 ≤14 years</td>
<td>304(23.0)</td>
<td>199(25.3)</td>
<td>105(19.7)</td>
<td></td>
</tr>
<tr>
<td>&gt; 14 ≤16 years</td>
<td>423(32.0)</td>
<td>240(30.5)</td>
<td>183(34.3)</td>
<td></td>
</tr>
<tr>
<td>&gt; 16 years</td>
<td>416(31.5)</td>
<td>231(29.3)</td>
<td>185(34.6)</td>
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<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>668(52.0)</td>
<td>413(52.4)</td>
<td>275(51.5)</td>
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</tr>
<tr>
<td>Female</td>
<td>634(48.0)</td>
<td>375(47.6)</td>
<td>259(48.5)</td>
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<td><strong>Race</strong></td>
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<tr>
<td>White, non-Hispanic</td>
<td>673(50.9)</td>
<td>405(51.4)</td>
<td>268(50.2)</td>
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</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>488(36.9)</td>
<td>298(37.8)</td>
<td>190(35.6)</td>
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<tr>
<td>Other</td>
<td>156(11.8)</td>
<td>82(10.4)</td>
<td>74(13.9)</td>
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<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not fielded</td>
<td>3(2.0)</td>
<td>3(1.00)</td>
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</tr>
<tr>
<td>East Tennessee</td>
<td>488(36.9)</td>
<td>289(36.7)</td>
<td>199(37.3)</td>
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<tr>
<td>Middle Tennessee</td>
<td>521(39.4)</td>
<td>311(39.5)</td>
<td>210(39.3)</td>
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<tr>
<td>West Tennessee</td>
<td>310(23.4)</td>
<td>188(23.9)</td>
<td>122(22.8)</td>
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<tr>
<td><strong>Psychological care</strong></td>
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<td></td>
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<tr>
<td>No</td>
<td>585(40.4)</td>
<td>352(44.7)</td>
<td>233(43.6)</td>
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</tr>
<tr>
<td>Yes</td>
<td>736(50.8)</td>
<td>436(55.3)</td>
<td>300(56.2)</td>
<td></td>
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<tr>
<td><strong>Custody for neglect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td>505(38.2)</td>
<td>300(38.1)</td>
<td>205(38.4)</td>
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<tr>
<td>Yes</td>
<td>799(60.4)</td>
<td>477(60.5)</td>
<td>322(60.3)</td>
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<tr>
<td><strong>Custody delinquency</strong></td>
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<td></td>
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<td>No</td>
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<td>372(47.2)</td>
<td>255(47.8)</td>
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<tr>
<td>Yes</td>
<td>676(51.1)</td>
<td>404(51.3)</td>
<td>272(50.9)</td>
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</tr>
<tr>
<td><strong>Lives in urban area</strong></td>
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<tr>
<td>No</td>
<td>578(43.7)</td>
<td>343(43.5)</td>
<td>235(44.0)</td>
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</tr>
<tr>
<td>Yes</td>
<td>734(55.5)</td>
<td>349(55.7)</td>
<td>295(55.2)</td>
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</table>
### Table 2: Correlations

<table>
<thead>
<tr>
<th></th>
<th>M(std)</th>
<th>M Health</th>
<th>F Closeness</th>
<th>S Support</th>
<th>H Stability</th>
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</thead>
<tbody>
<tr>
<td>M Health</td>
<td>10.36(10.41)</td>
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<td></td>
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<tr>
<td>F Closeness</td>
<td>7.96(3.62)</td>
<td>-.112**</td>
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<tr>
<td>S Support</td>
<td>4.30(3.58)</td>
<td>-.096**</td>
<td>.166**</td>
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<td></td>
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<tr>
<td>H Stability†</td>
<td>.47(0.50)</td>
<td>-.306**</td>
<td>.182**</td>
<td>.178**</td>
<td></td>
</tr>
<tr>
<td>P Stability†</td>
<td>.35(0.48)</td>
<td>-.054</td>
<td>.62*</td>
<td>.052</td>
<td>.082**</td>
</tr>
</tbody>
</table>

*p ≤ 0.05, **p ≤ 0.01  † Point-Biserial Correlations

### Table 3: Regression on Mental Health

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>F</th>
<th>P</th>
<th>95% CI</th>
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</thead>
<tbody>
<tr>
<td>Constant</td>
<td>19.87</td>
<td>&lt;0.001</td>
<td></td>
<td>59.46</td>
<td>&lt;.001</td>
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<tr>
<td>F Closeness</td>
<td>-0.059</td>
<td>-2.03</td>
<td>0.043</td>
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<td></td>
<td>-0.005,-.333</td>
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<tr>
<td>H Stability†</td>
<td>-0.295</td>
<td>-10.17</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td>-4.97,-7.35</td>
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</tbody>
</table>

### Table 4: Independent t Test for YVLifeSet and Not YVLifeSet

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SE</th>
<th>YVLifeSet</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>Not YVLifeSet</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>95% CI</th>
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<tbody>
<tr>
<td>M Health</td>
<td>1.30</td>
<td>.63</td>
<td>9.83</td>
<td>10.02</td>
<td>659</td>
<td>11.13</td>
<td>10.91</td>
<td>455</td>
<td>2.05</td>
<td>1112</td>
<td>.040</td>
<td>2.54, .059</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Stability</td>
<td>.193</td>
<td>.079</td>
<td>.99</td>
<td>1.24</td>
<td>657</td>
<td>1.18</td>
<td>1.322</td>
<td>454</td>
<td>2.46</td>
<td>931.82</td>
<td>.014</td>
<td>.348, .039</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

I. Placement Instability Baseline Questionnaire
   1. How many different state custody placements have you had?

II. Housing Instability Scale
   1. How many different times have you found yourself homeless for one or more nights during the past 12 months? By homeless I mean that you have slept in a homeless shelter or in a place where people weren't meant to sleep because you didn't have a place to stay.
   2. How many different times have you found yourself couch surfing for one or more nights during the past 12 months? By couch surfing, I mean staying temporarily with your friends, family, or strangers because you didn’t have a permanent place to stay.
   3. Was there ever a time when you could not pay your rent because you did not have enough money?
   4. Was there ever a time when you were evicted from your apartment or lost your home or were asked to leave where you were living because you did not have enough money to pay your rent?

III. Social Support Scale
   1. How many people can you count on to invite you to go out and do things?
   2. How many people can you talk to about money matters like budgeting or money problems?
   3. How many people give you useful advice about important things in life?
   4. How many people could you count on to help you if you had transportation problems?
   5. How many people can you go to when you need someone to listen to your problems when you're feeling low?
   6. How many people can you go to when you need help with small favors?
   7. How many people would lend you money in an emergency?

IV. Familial closeness
   1. Some people feel close to their mother, father or other relatives; others don't feel close at all. The next set of questions asks about how close you feel to these relatives these days:
      i. In general, would you say that you feel very close, somewhat close, not very close, or not at all close to your…
         a. Biological mother?
         b. Biological father?
         c. Step-mother?
         d. Step-father?
         e. Grandparents If you are close with more than one grandparent, think of the one you are closest with.
         f. Adult brothers or sisters, including step-brothers and step-sisters?
If you are close with more than one adult brother or sister, think of the one who you are closest with.

V. Mental Health Problems Scale: Depression Anxiety Stress Scale (Dass-21)

In the last week, did this apply to you…
1. I found it hard to wind down.
2. I couldn't seem to experience any positive feeling at all
3. I experienced breathing difficulty, such as breathing very rapidly or breathlessness when I was not exerting myself physically
4. I tended to overreact to situations. In the last week, did this apply to you…
5. I experienced trembling, such as trembling in my hands
6. I was worried about situations in which I might panic and make a fool of myself
7. I felt that I had nothing to look forward to. In the last week, did this apply to you…
8. I found it difficult to relax
9. I felt down-hearted and blue
10. I felt I was close to panic. In the last week, did this apply to you…
11. I was unable to become enthusiastic about anything
12. I felt that I was rather touchy
13. I was aware of the action of my heart without exercising, such as a feeling of my heart rate increasing or my heart missing a beat. In the last week, did this apply to you…
14. I felt scared without any good reason
15. I felt that life was meaningless
16. I was aware of dryness of my mouth. Over the past week, did this apply to you…
17. I found it difficult to work up the initiative to do things… Over the past week, did this apply to you…
18. I felt that I was using a lot of nervous energy… Over the past week, did this apply to you…
19. I found myself getting agitated… Over the past week, did this apply to you…
20. I was intolerant of anything that kept me from getting on with what I was doing… Over the past week, did this apply to you…
21. I felt I wasn't worth much as a person… Over the past week, did this apply to you…