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Predictors for resolution of antisocial behavior among foster care youth receiving community-based services

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ABSTRACT

Youth in the foster care system are more likely to be diagnosed with mental illness than those in the general population. Within this system, youth with antisocial behavior (e.g., aggressive, oppositional) are overrepresented. The challenges youth with antisocial behavior present to foster care systems make understanding the factors that predict remission in this population important for improving placement stability. Using Optimal Data Analysis (ODA), this study examines potential moderating effects of various individual, social, and strength variables on clinically significant decreases antisocial behavior in a sample of foster care youth over time. Results revealed positive improvements in youths' wellbeing to be the optimal predictor of resolution, followed by positive changes in family functioning and positive changes in adjustment to trauma (i.e., symptoms of PTSD). These results indicate that clinically significant decreases over time in antisocial behavior were associated with concurrent improvement in individual and environmental variables. Implications for service providers working with this population are discussed.

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1. Introduction

Not surprisingly, youth in the foster care system are more likely to experience psychological problems compared to those in the general population (Burns et al., 2004; Landsverk & Garland, 1999). Youth with antisocial behavior are particularly overrepresented in the foster care population (Pilowsky & Wu, 2006). For example, White, Havalchak, Jackson, O'Brien, and Pecora (2007) found that 20% of youth in a foster care sample they studied had a diagnosis of Conduct Disorder, compared to only 7% in the general population. The presence of antisocial behavior presents a unique challenge to stakeholders in the foster care system, since it leads to more negative and severe long-term outcomes, including chronic deviant behavior such as theft, alcohol abuse, and sociopathy (Offord & Bennett, 1994). Further, these youth experience more challenges with placement in foster homes (Rolock, Koh, Cross, & Eblen-Manning, 2009) and have poorer placement stability (Barber, Delfabbro, & Cooper, 2001).

Youth with antisocial behavior in the foster care population are also at an increased risk of stepping up in care, due to difficulty managing their behavior issues in a community setting (Hussey & Guo, 2005). Further, the most significant predictors of stepping up to higher levels of care include a history of criminal and/or delinquent behavior, elopement risk, and inappropriate sexual behavior, all which are included under the umbrella of antisocial behavior (Park, Jordan, Epstien, Mandell, & Lyons, 2009). Congregate care placement is particularly problematic for youth with antisocial behavior. Iatrogenic effects have been reported for youth in group-based care with disruptive behavior issues (Poulin, Dishion, & Burraston, 2001; Robst et al., 2011). When comparing congregate care to treatment foster care, Robst et al. (2011) found more negative effects following congregate care, including greater post-treatment felony charges and return to out-of-home and residential treatment placements. Negative effects have been found to be most robust for youth with initially low levels of delinquency (Poulin et al., 2001), highlighting the negative influence of group care on youth with antisocial behavior.

The evidence that youth with antisocial behavior are at an increased risk of stepping up to a higher level of care and that the experience of this type of care is associated with poorer outcomes underlines the importance of community-based care options for this group of youth. With the significantly increased rates of mental health needs among youth in foster care, the child welfare system has been described as a "de facto public behavioral health care system" (Lyons & Rogers, 2004), prompting state child welfare agencies to seek to put systems and policies in place to appropriately match youth needs with the most effective treatments. In 1986, the Child and Adolescent Service System Program (CASSP) put forth a landmark proposal that set the stage for what would become the System of Care (SOC) model. The most consequential element of the SOC model holds that the community should be the centerpiece of any service system and should always be considered the treatment setting of choice (Stroul & Friedman, 1986, 1994). The SOC model also calls for services to be

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(a) delivered in the least restrictive environment, (b) individualized, (c) coordinated, (d) delivered as close to youths' home as possible, (e) involve all available adults in youths' lives, (f) recognize youth strengths, and (g) be culturally competent.

The Wraparound approach to care is one of a few specific treatment modalities that is consistent with the SOC philosophy and has been found to be effective for youth with disruptive behavior disorders (Burchard, Bruns, & Burchard, 2002). Wraparound is a direct treatment application of the broad SOC model. Using existing community services and natural supports, the Wraparound system is a family-centered and child-focused intervention that capitalizes on youth strengths, creating an individualized, community-based treatment program that it is interagency coordinated and culturally competent (Burchard et al., 2002; Burchard, Burchard, Sewell, & VanDenBerg, 1993; VanDenBerg & Grealish, 1998).

In 2002, the state of Illinois responded to the call to serve youth in their communities by developing a statewide community-based program designed to provide multi-modal services to at-risk youth in substitute care. The program was designed by the Illinois Department of Children and Family Services (DCFS) for children and adolescents who are capable of community functioning but were either at-risk of stepping up to specialized foster or residential care or were stepping down from these higher-level placements. The Illinois model, called community "SOC," uses a Wraparound approach to treatment, which has been shown to be successful in the mental health, child welfare, and juvenile justice systems (Burchard et al., 2002). This approach is community-based and individualized; therefore, it is consistent with, but not identical to, an SOC approach to service planning and delivery.

Prior research has found positive mental health outcomes for Illinois' community "SOC." One study reported modest positive change in outcome trajectories on a composite measure clinical severity (Sieracki, Leon, Miller, & Lyons, 2008) and another stated that the SOC program is beneficial in preventing placement disruption in foster care youth (McClelland & Schneider, 2009). However, the limitation of this and other prior research in the behavioral health outcomes literature is that outcomes were studied using "main effects" predictors, and failed to test whether the outcome effects were moderated by other clinical variables, social context variables (e.g., caregiver issues) or individual strengths (e.g., psychological, educational). Further, prior research has used composite measures of emotional and behavioral problems and has not disaggregated youth by presenting problem type (e.g., diagnosis) to determine the potentially unique predictors of outcomes for these specific youth. Given the incidence of antisocial behavior in the foster care population, the unique risk these youth have of stepping up to higher levels of care, and the potentially chronic and severe negative outcomes associated with externalizing behavior, it is particularly appropriate to study the variables that specifically predict maintenance versus clinically significant decreases in antisocial behavior. The current study addresses these gaps in the literature by examining the potentially moderating effects of a range of individual, social, and strengths variables on decreases in antisocial behavior in a sample of foster care youth who are at risk of stepping up to residential care.

In order to create a model for predicting clinically significant decreases in antisocial behavior among youth in foster care, Optimal Data Analysis (ODA) was used (Soltysik & Yarnold, 1993; Yarnold & Soltysik, 2005). ODA is an exploratory, non-parametric data analysis method that maximizes the accuracy of the model created from the data sample. ODA's method of statistical analysis is best suited for the current study. The approach to the testing of multivariate interactions used by ODA allows for an unlimited number of variables to be tested to fit into the optimal predictive model. Traditional analyses, such ANOVA and regression, require the selection of specific predictors to be tested in a pre-described model. ODA permits the inclusion of an unlimited number of possible predictors without the specification of hypothetical interactions. Although some researchers argue that only those variables with supporting evidence in the literature should be included in the model of analysis, the techniques used by ODA are able to accommodate an unlimited number of variables without increasing the chance of error (Yarnold & Soltysik, 2005). By not placing restrictions on those variables included in the model, ODA allows variables not previously explored to be examined for involvement in mental health outcomes for youth in foster care. Additionally, ODA permits the creation of subgroups and the examination of moderators within the context of the model, rather than each variable needing to have a predictive effect for the entire group, as is the case in traditional models. For example, gender may moderate the effect of family functioning on the remission of antisocial behavior in youth in foster care. The methodology of ODA allows for the creation of a model that identifies the strongest predictors for each subgroup of the sample (Yarnold & Soltysik, 2005).

Based on the previous literature with this clinical population (e.g., Coie & Dodge, 1998; Hinshaw & Lee, 2003; Moffitt, 1993), a range of variables across the individual and his or her ecologies are suggested to predict outcome. However, it is important to note that the overwhelming majority of variables studied in the child and adolescent antisocial behavior literature have been main effects variables. The literature offers very little guidance on what will emerge from an exploratory statistical analysis designed specifically to unearth highly distinct moderations — many ODA studies unearth up to four or five total interactions. Therefore, the hypotheses below apply to the univariate ODA analyses that will be run and not to the final multivariate ODA results. With this caveat in mind, in the present study, we propose that being female, and the individual and social/ecological variables of having low reported danger to others, positive social behavior, high interpersonal strengths, and/or positive family functioning will predict decreases in antisocial behavior among youth.

2. Method

2.1. Participants

The subsample used for this study consisted of 77 children and adolescents referred to community-based SOC treatment who were rated by their caseworker team as exhibiting significant antisocial behavior; these youth were taken from a larger sample of 503 youth. The study period was between September 1999 and December 2004. The participants received treatment from 16 different service agencies from throughout Illinois. The sample was 36% female and 64% male. At initiation of treatment, the average age of the participants was 12.05 years old. The race/ethnicity of the sample was as follows: 71% African American, 21% European American, 4% Latino/a, 3% Asian American.

2.2. Materials

Youth outcomes were evaluated using the 44-item version of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH; Lyons, 1999). This assessment tool was developed to guide service delivery for children with emotional and behavioral healthcare needs. The CANS-MH instrument assesses the needs and strengths of a child or adolescent across multiple domains and is used as an assessment, decision-support and outcome measure instrument (State of Illinois Department of Child and Family Services, 2009) and has been consistently shown to be a reliable and valid assessment tool (Anderson, Lyons, Giles, Price, & Estes, 2002; Lyons, 1999).

The CANS-MH consists of 44 items across 6 factors: symptoms, risk factors, functioning, care intensity and organization, placement/system factors/caregiver needs and strengths, and child strengths. Severity ratings are reported along a four-point scale, from 0 to 3. Across all needs

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