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Feeling Heard and Not Judged: Perspectives on Substance Use Services Among Youth Formerly in Foster Care

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Abstract

Youth in foster care have limited access to substance use services for a variety of reasons. Attempts to unpack this health disparity have focused on foster care systems, administrators, providers, and foster parents. This study seeks to understand the perspectives of youth themselves, with the hope of understanding their experiences with and preferences for such services. Analyses of focus groups with youth who had recently left foster care suggested concrete and perceptual facilitators/barriers to treatment. Concrete facilitators/barriers included the need for expanding social support, access to multiple service options, and tailored intervention approaches. Perceptual concerns revolved around understanding each individual's readiness to change, feeling judged by authority figures, and desiring help from people with lived experience. Participants also described novel intervention ideas, including a focus on technology-based approaches. By relying on youth voices, we can improve upon the current state of substance use interventions within foster care.

Keywords

substance abuse; foster care; intervention; qualitative research; technology; support

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Recent estimates indicate that over 400,000 young people reside in the U.S. foster care system (U.S. Department of Health and Human Services, 2015). Preceding foster care, these youth are exposed to high rates of adverse childhood experiences (ACEs), including maltreatment, neglect, parental substance use, and domestic violence. Indeed, youth in foster care report over 50 times the rate of being exposed to four or more ACEs compared to young people in two-parent homes (Bramlett & Radel, 2014). While ACEs are related to myriad negative outcomes, their association with increased alcohol and drug use is particularly pronounced (Dube et al., 2003, 2006). In addition, ACEs and substance use have a dose–response relationship, with more exposure leading to increased substance use severity (Dube et al., 2003).

Not surprisingly then, youth in foster care tend to initiate substance use earlier and use alcohol and drugs more frequently and severely than their peers in the general population (for a review, see Braciszewski & Stout, 2012). As youth exit the foster care system, diagnostic rates continue to escalate and do so rapidly. Longitudinal data indicate an increase of 11% and 13% for alcohol and substance use disorders, respectively, within 1 year of emancipation (Courtney et al., 2005). Comparatively, these rates among general population youth of the same age are approximately 1–2% (Substance Abuse and Mental Health Services Administration, 2009). Attention to substance use is clearly paramount while youth are in care, so as to mitigate any potential long-term effects of early initiation and problematic use.

Entry into foster care provides an excellent opportunity to screen and assess for substance use. Indeed, the American Academy of Child and Adolescent Psychiatry and Child Welfare League of America (2002) released a joint policy statement calling for such a protocol. However, even with a connection to Medicaid and other state-supported services, youth in foster care tend not to be assessed for substance use problems or referred to empirically supported treatment (Casanueva, Stambaugh, Urato, Fraser, & Williams, 2011; Cheng & Lo, 2010). A review of child welfare system records indicated that 5 years after the joint policy statement calling for screening and assessments, few states had implemented these procedures for youth entering foster care (McCarthy, Van Buren, & Irvine, 2007). This finding is particularly worrisome, not only due to the high likelihood of exposure to ACEs but also because a substantial number of youth in foster care report having a caregiver with alcohol and/or drug problems (Courtney, Terao, & Bost, 2004).

In cases where substance use services are made available, little is known about effective engagement for this population. However, a few studies have suggested population-specific barriers for engaging in care. For example, developing a strong, trusting alliance with a health-care provider may be difficult for youth in foster care, given previous maltreatment by individuals in authority (Braciszewski, Moore, & Stout, 2014). When youth grow up within systems of care, such mistrust can develop for the system as a whole (Davis, 2003) and any associated aspects; thus, youth may feel that substance use treatment providers, working for a system, will not have their best interests at heart (Braciszewski et al., 2014). Indeed, in a study of youth perspectives on mental health treatment, youth in foster care reported feeling overmedicated and ignored and perceived that that providers were allied with the foster care system, rather than being there for the benefit of the young person (Lee et al., 2006).

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Abstinence from substances is sometimes required for participation in certain child welfare programs, creating a fear of negative consequences for admitting to substance use and, therefore, a disincentive for youth to seek treatment options (Braciszewski et al., 2014; Meyers, White, Whalen, & DiLorenzo, 2007). Finally, while case managers and foster parents are likely the most proximal to youth and serve as gatekeepers to services, many have not received the requisite training to identify and address substance misuse (Meyers, Kaynak, Clements, Bresani, & White, 2013; Schroeder, Lemieux, & Pogue, 2008). This lack of knowledge may prevent these important figures from presenting the idea of substance use treatment to young people in a comprehensive and nonjudgmental way.

Recognizing the “voice of the patient” can be a critical step in designing and successfully implementing health-care interventions (Gabriel & Normand, 2012). Indeed, programs developed with the input of young people are more likely to be appealing and engaging to that population (D’Amico & Edelen, 2007). Such an approach can help decrease barriers and increase the likelihood of success. Despite the advantage of collecting youth opinions, the limited research on substance use service engagement by youth in foster care has focused almost exclusively on foster care staff, administrators, treatment providers, or foster parents (Braciszewski et al., 2014; Meyers et al., 2013). Because the priorities of these caregivers and supports may differ from the priorities of youth themselves, they may not accurately portray youths’ experiences of service receipt or desire to seek treatment (Lee et al., 2006). Any further conjecture would come from studies of mental health or general service engagement (Davis, 2003; Kerns et al., 2014; Schneiderman, 2004; Schneiderman, Brooks, Facher, & Amis, 2007; Simms, Dubowitz, & Szilagyi, 2000), which may not apply, given the stigma and marginalization associated with substance use and treatment (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

Given that substance use among youth in foster care is substantially higher than in the general population (McDonald, Mariscal, Yan, & Brook, 2014; Pilowsky & Wu, 2006; White, Havalchak, Jackson, O’Brien, & Pecora, 2007), it is paramount to understand how we can better engage these vulnerable young people in substance use services. As mentioned, understanding their viewpoints and experiences can help increase the chances of effective engagement. While Meyers, White, Whalen, and DiLorenzo (2007) asked youth about their consideration of substance use treatment, this inquiry consisted of one follow-up question amid a comprehensive study of improving discharge planning among homeless young adults who had aged out of care. Accordingly, we are not aware of any studies that have focused specifically and extensively on substance use service engagement using the perspectives of this underserved group.

The aims of this study, therefore, were to identify ways in which to increase engagement with substance use treatment by understanding preferences for and barriers to services for youth formerly in foster care. Such an approach has the potential to uniquely augment engagement strategies and services currently being offered in child welfare agencies across the country. Moreover, we aim to use this feedback from youth to design a new substance use intervention that is innovative in addressing these barriers and will help engage youth in the process of reducing and abstaining from substance use. To achieve these aims, we

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conducted focus groups with youth who used substances and had recently exited the foster care system.

Method

Participants

Young adults were recruited from a large New England agency serving individuals receiving postfoster care services. Inclusion criteria were (1) 18–19 years old; (2) no more than 2 years removed from state custody/foster care; (3) a score of moderate or severe risk on the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), a measure of substance use severity shown to be reliable and valid across settings (Humeniuk et al., 2008; WHO ASSIST Working Group, 2002); (4) not currently in or seeking substance abuse treatment; (5) own a mobile phone; and (6) use text messaging at least weekly. Young people were identified through fliers and referral by agency staff and were then invited to be screened. Flyers advertised a general health study for youth who were formerly in foster care aged 18 or 19. Agency staff referred youth to study interviewers using the same criteria (i.e., they asked any 18- or 19-year old in the program if they were interested in hearing more about a health study).

A total of 89 young adults were screened, of whom 41 (46%) were eligible. The most common reasons for ineligibility were low risk use of substances ($n = 32$) and no lifetime use of substances ($n = 12$). Seventeen youth did not participate in a focus group because of scheduling issues. Of the 24 who participated in the focus groups ($n = 6$, 3–6 participants per group), 38% were female and 54% of the sample indicated a Hispanic/Latino ethnicity. Twenty-nine percent reported their race as Black/African American, 62% as Caucasian, 4% as American Indian/Alaskan Native, and 4% as Asian. Within these categories, 17% reported more than one race. Almost two thirds (62%) were currently employed and participants averaged roughly 11 years of education ($SD = 2.02$). Length of time in foster care ranged from 1 to 15 years ($M = 4.04$, $SD = 3.42$), with an average of 6.04 placements ($SD = 8.02$).

Procedure

Participants attended one focus group each, the primary goal of which was to provide qualitative feedback on preferences for a hypothetical preventive substance use intervention. Focus group members engaged in open-ended discussion with facilitators on participant ideas for substance use prevention, which was guided by a semistructured script (see Appendix). As strong theories on substance use service engagement among youth in foster care do not exist, we chose a client-centered approach, allowing the data to reveal opportunities for engagement and barriers to treatment. Participants were initially briefed with regard to confidentiality in a group setting, were informed that the group would be audio recorded, and provided written, informed consent for participation. Groups began with a rationale for the study, mainly that substance use tends to markedly increase after youth exit foster care and that the researchers were interested in developing a program to curb this postexit spike. Focus group leaders explained that the success of such an intervention would likely be greater with the input of the participants. Initial inquiries were very broad (i.e.,

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"grand tour" questions), as participants were asked for ideas about intervention content with no prompting by the group facilitators. This was done purposefully to mitigate the perception that researchers were advocating any specific approach, particularly one that has been used in traditional ways with the general population (e.g., one-on-one counseling). As participants offered ideas, leaders asked more direct questions about potential intervention features. In each group, this organically led to a discussion of both positive and negative previous experiences with substance use interventions and interactions with authority figures (e.g., case managers, foster parents) around this issue.

Groups were cofacilitated by the first two authors and lasted between 1 and 1.5 hr each. The facilitators had extensive experience with conducting focus groups and were trained to avoid leading questions and to interact with the respondents in a matter-of-fact, value-neutral manner. Appropriate ethical human subjects guidelines were followed, and the study procedures were reviewed and approved by the Pacific Institute for Research and Evaluation Institutional Review Board, according to National Institute of Health regulations.

Data Analytic Strategy

Audio recordings were transcribed verbatim for use in coding and analysis, which consisted of identifying emergent themes through the principals of thematic analysis (Braun & Clarke, 2006). Coding proceeded in an iterative fashion. Specifically, the first and last author independently read two focus group transcripts in their entirety and assigned preliminary codes to those first two transcripts. The coders then met to discuss their respective preliminary code lists, identify any discrepancies (e.g., title and/or meaning) in coding, and create a final list of codes. The final list was first constructed by creating parent themes (e.g., barriers to changing substance use); subsequent child codes were agreed upon that offered further detail, where appropriate (e.g., barriers: lack of support, barriers: no negative consequences). This master codebook was then used to independently analyze the final four transcripts. Coders met weekly to discuss their ratings, including new parent and/or child codes that were created for text that did not fit the current version of the codebook. As new codes were added, coders reexamined previous transcripts and amended as necessary. Discrepancies resulted in reexamination of the text in question, as well as previous transcripts with similar text selections, until agreement was reached. The third author remained available in the event that consensus could not be reached, but this did not occur. Dedoose (SocioCultural Research Consultants, 2016), a web-based software for analyzing mixed methods data, was used to conduct the analyses.

Results

Several major themes emerged that described both facilitators and barriers to substance use treatment/services, each of which is described below, with illustrative quotations selected to help explicate the identified recurring themes. Each theme could also be categorized as describing either perceptual or concrete facilitators/barriers. We begin first with perceptual concepts, followed by tangible, concrete mechanisms.

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Perceptual Facilitators and Barriers

Understanding a person's readiness to change—As mentioned, participants were initially asked, in a broad and general way, how they would address substance use among youth in foster care. These young adults were quick to identify readiness to change as an important factor when talking with someone about the misuse of substances. One participant indicated:

> You can only lead a horse to water, you can't make him drink it. You can't do everything for him, they have to want it.

Many other group members voiced similar concerns. For example, another group member stated:

> There's nothing you can really do. If someone doesn't want help, they can't be helped. They have to want to be helped.

One young person provided a more elaborate comment about how secondary gain and a lack of negative consequences will likely lead to maintenance of unhealthy behaviors:

> … the person that doesn't want any help, feels as though, "I can drink, it doesn't matter. I'm still alive." As they see it, it's not killing them, it's just helping them cope with whatever their problem is. And that person has to come to the realization that, "Oh, this is killing me slowly. I'm ready to change."

Participants were not optimistic about changing the views of those who expressed low readiness:

> If they don't want help, what can you do? You can't help someone who doesn't want help. If he feels as though he's doing fine, there's nothing you can tell him to change his mind. You can sit there and constantly talk and talk and talk, but if he feels as though there's absolutely nothing wrong with the situation, what can you do?

Understanding readiness to change is clearly an important concept for these young people. Indeed, this topic came up at least once in every group, with 17 total excerpts, each one at great length. Given how much these young people are forced to change by factors outside of their control, it is not surprising that they are acutely aware of forceful attempts at change.

Feeling judged and controlled—Given that all participants had experiences with the misuse of substances, many had examples of reaching out to peers, coworkers, family, case managers, health-care providers, and other caregivers for help. On the whole, however, these young people often felt judged for their choices, thoughts, and behaviors, which then turned them off from seeking further comfort, advice, and support. One focus group member stated:

> Like, say you fall off the tracks… I know what it's like to fall off and get shut out and it's like, "Oh, well, I thought you were supposed to be there for me." Family and friends, real family and friends, are not supposed to just shut you out for a mistake.

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Another echoed this idea, adding that supports can often be overwhelmed by the experiences of youth in foster care:

> When I was seeing a psychiatrist… I'd write in a journal and… I let her read my journal and she got halfway through it and she had tears in her eyes and she's like, "I really think you need to go to the hospital." See, I don't want to do that, I don't want to talk to someone who I know's got the advice for me and who I know can help me, but you're going to judge me and tell me I need to go to the hospital because I think what I think?

Several group members felt that caregivers and others had a low threshold for mistakes coupled with high expectations for the young people. A group member expressed frustration at caregivers' lack of patience and empathy, pointing out:

> You want the people that you care about… they want to see you feel better, but when it becomes a nagging, almost, "Why aren't you better yet?" that's when you just don't want anyone to voice their opinion. No one wants to see someone they care about get into drugs… but when you're just angry at someone because they're on that path, being angry at someone is not going to snap them out of it, it's going to piss them off more and be like, "Alright, screw you. I don't want to talk to you at all."

Another participant added this sentiment, indicating that pressure and high expectations can be daunting for a young person:

> I feel like giving them [someone who needed help] an ultimatum would also… make them feel as though you're pressuring them or starting to be negative towards them… because if they don't think that they have a problem, then they're not going to take anybody's advice.

Others expressed fear of and experience with significant negative consequences after reaching out to supports. One group member indicated:

> Yeah, talking with your case managers… makes you feel like you're gonna get into a lot of trouble or it can affect your living situation and that can make you use more or try to block out all of the bad feelings that may come from that.

Often, youth felt that rather than offering encouragement and a sounding board, caregivers, case managers, and other providers gave them direct and unsolicited advice. Two participants summed up this experience of receiving judgmental advice from others quite succinctly, within this volley:

> [P1, pretending to be a caregiver or case manager] But… an adult, they'll be like, "Yeah, but. Yeah, but. Yeah, but."
>
> [P2] "I get you want to do you, but you're doing you wrong, alright?" I hate when they do that.
>
> [P1] Or, "Find a better way to do it."

Participants were fervent in their desire to have interventions use a nonjudgmental approach, predominately expressed through negative experiences. This came up a total of 19 times, at

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least once in each group, and again, at significant length each time. As newly independent young adults, these youth are finding a voice and loudly saying that they no longer want to be controlled and wish to be treated in a fair and nonjudgmental way.

Needing someone with lived experience—As more detailed aspects of a hypothetical intervention were discussed, more than half of the groups (10 excerpts) endorsed incorporating individuals who had similar experiences. That is, the experience of hearing personal stories was highlighted as a turning point for many youth. One group member commented:

> If I had a problem, like a really big problem with drugs and alcohol, I would want to see people who have actually had that problem. Like show pictures or something. Like put pictures of people who, I don't know, who have had that problem.

Another participant echoed the desire to speak with someone who had a similar background:

> Well, mostly you want to talk to someone who can relate to the experiences you've been through and half the time, you don't think those people can relate to that kind of experience.

Many group members suggested the idea of having videos of such individuals to view on their phones or within a web-delivered intervention. One participant stated:

> It's also important where you can have someone you can relate to. I used to love when I was in a group home and when a staff would like tell me some of their personal stories 'cause they're not allowed to do that. … they would tell me how they would smoke weed when they were younger and they know exactly how I feel. Like one of them has been in group homes before and they would tell me about their experiences and it's better to relate to someone cause they know how I feel. They're not just gonna be like, "Yeah, I can't really relate to you, but I can see by how you are that you're sad and blah blah blah." You need to know. You need to actually have been in this place.

A young woman summed up this idea by saying:

> Other people's stories, which [are] always interesting to hear. When I go to school and things like that, we always have a guest speaker come in or whatever ….they'll talk about their stories and stuff, and a lot of times, it really makes me think, it really relates to a lot of the things that I've done. And it went well, clearly, because I'm still alive, but it could've went in the opposite direction.… Like if you would have videos of people's stories and stuff and how things could go good and go bad. … It would have to be people that their situations went extreme in both directions. People are like, "I did this, this, and that, but I got extremely lucky and my life turned out great," but then people who are like, "I did the same thing and it just went in the wrong direction so it could really happen to anyone."

The request for support from someone who has "been there" is evident throughout many stressful life experiences. Youth who have been raised in foster care certainly have a unique set of experiences, which can lead to feeling isolated. Given the heavy judgment they report

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receiving from people who have not been a part of the foster care system, it makes intuitive sense that they would seek help from people they perceive to be more similar.

Concrete Facilitators and Barriers

Building strong social supports—Participants indicated that, for individuals who identified the desire, ability, or need to change, social support and help from others would be necessary aspects of any program. One youth stated:

> You need support from other people who are doing good and not other people who are also using or drinking or anything.

Others indicated that a literal shoulder to cry on would prove helpful:

> If you have someone to cry to, it's easier because then they can comfort you, they can make you feel better about yourself instead of turning to the other things. So I would just be there and support them, help them when they needed it, as long as it's reasonable and make them finally smile, make them feel good about themselves and hopefully they'll start to get clean on their own.

Despite identifying social support as a key aspect of substance use interventions, a substantial minority of youth indicated that such supports had not been afforded to them. A popular refrain throughout the groups was that, "some people don't have parents to go talk to." As one youth tried to explain how she would help others in her situation, she stated:

> I just needed someone to be there for me, you know? I just needed someone to be like, "I understand that you have done some pretty bad things in your life, but I'm here to help." That probably would've helped me out more than anything.

Others added that some individuals who purported to help them, actually had a negative influence, through negative comments and ridicule. One participant stated:

> I would just be a support system…. I basically was on my own since I was 13…. I never had a support. I never had someone telling me, "Do this, do that." I had a lot of people telling me, they were basically bashing me… always bringing me down… so I just went out and did more [drugs].

Despite being involved in a system designed to support and nurture these young people, many of them (over half of the groups, 10 excerpts) emotionally described their desire for people to care about them. Mentoring roles will likely still be important for these young people, even after emancipation.

Designing tailored interventions—The idea of a tailored, individualized program permeated every focus group (12 excerpts). Participants consistently commented that, "everyone's different" and "what works for one person, won't work for another person." Interventions would need to understand "where people are at" and "why they starting using in the first place." One group member indicated:

> You have to assess the situation and how they got into what they're doing. Cause some people do it for fun and some people do it as a releaser and escape. So it's not really just one solution for everything.

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Others realized that more than one option was necessary:

> You could come up with like 3 or 4 solutions and categorize people into, “Well, these people need this solution and those people need that solution.”

Another group member agreed with the need for customization but also poignantly described the challenges in such an approach:

> I mean, every person’s different. They’re all doing it for their own reasons, they all won’t stop for their own reasons and as much as I hate saying it, the program itself would have to be as diverse, if not more, than the people using it. And that’s going to be difficult to pull off.

Participants identified that, while they all have the common experience of foster care, each person is individual and may require their own approach to substance use recovery. Such individuality may be suppressed while residing in a system of care; thus, as youth leave care, expressing themselves and their uniqueness may be at the forefront.

Discussion

Many youth in foster care who misuse substances have a strong desire to become abstinent or reduce their use of alcohol and other drugs. Despite this search for collaborative help, programs to reach these vulnerable young people often do not meet their needs and, in some cases, exacerbate unhealthy behaviors. Focus group participants shared myriad examples of feeling judged and belittled by the authority figures (e.g., case managers) who are in place to promote health and self-efficacy, making them reluctant to share their struggles with substance misuse. Such mistrust of authority figures has been noted in another study of foster youth (Lee et al., 2006), as well as foster care administrators, parents, and staff (Braciszewski et al., 2014). Such an approach seems to be unfortunately common in adult substance use treatment, as the negative attitudes of health-care providers have resulted in decreased patient feelings of empowerment and worsened treatment outcomes (van Boekel et al., 2013). Similar to the experiences of these youth, substance use treatment providers tend to be more task oriented, rather than process oriented, leading to poorer patient–provider relationships (Peckover & Chidlaw, 2007).

The degree of impact that stigma and negative attitudes have on patient outcomes seems to vary as a function of specialty and training (van Boekel, Brouwers, van Weeghel, & Garretsen, 2014). Within child welfare, such training is not common. Indeed, training in substance use assessment, treatment, and prevention within social work education and child welfare curricula has frequently been absent (Schroeder et al., 2008), despite the high frequency of substance use among child welfare families (Courtney et al., 2004). Case managers have also self-reported a lack of training in the identification of mental health needs among their clients in child welfare (Kerns et al., 2014). Such education is also rarely offered to foster caregivers. In a survey of licensed foster parents, 40% had fostered a child who misused substances; however, less than two thirds of those parents (61%) received any type of training specific to parenting a child with such an issue (Meyers et al., 2013). Support for foster parents with substance-using youth was not universal, as 28% of parents indicated that their agency was not helpful when they were experiencing problems with their

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substance-using foster child, reflecting a possible lack of training on the part of case managers and other child welfare agency workers.

Social support—specifically support for abstinence from alcohol and drugs—is perhaps the most significant predictor of sustained abstinence (Kelly, Hoeppner, Stout, & Pagano, 2012). However, youth who have been exposed to adverse events in childhood have been shown to have smaller social networks (Ford, Clark, & Stansfeld, 2011). Indeed, several study participants were reluctant to endorse intervention features that promoted the utilization of support, noting that it often did not exist. Others stated that, where it does exist, supports are not often equipped to deal with the myriad issues many of these youth face. Participants added that yet another rejection or lack of resources made them feel further depressed, isolated, and more likely to use substances to cope. Previous research has, in fact, suggested that social support does not always protect against poor outcomes among maltreated and neglected youth (Appleyard, Yang, & Runyan, 2010). However, among foster care alumni who have succeeded by way of completing (or almost completing) postsecondary education, having support was listed among the most frequent protective factors (Hass & Graydon, 2009).

Participants also cautioned against using a direct approach with individuals who may not be ready to change. These young people are astutely touching on the academically and clinically popular concept of the stages of change or transtheoretical model (TTM; Prochaska & DiClemente, 1992). The TTM posits that behavior change occurs in increments along stages. Clinical approaches that follow the TTM advise that, for individuals at these different stages, clinician/program flexibility is needed in order to meet individuals where they are in terms of readiness to change. Given that youth in foster care may be struggling with multiple issues at once (e.g., depression, anxiety, trauma), this serves as a reminder that checking in on client readiness is an important first step in the behavior change process. Indeed, participants highlighted a key component of prominent substance abuse treatment theory, one that is likely necessary in a reorganization of approaches currently being used with this population.

Participants also described the desire to interact with other individuals who had experience with substance use recovery, consequences of substance use, and a history of foster care placement, echoing concerns about trust voiced by foster care staff and parents (Braciszewski et al., 2014). This is not altogether surprising, given the request of many clients to be treated by providers with similar backgrounds and experiences. Likewise, Alcoholics Anonymous and other mutual help organizations continue to be the most commonly sought source of help with alcohol and drug problems (Substance Abuse and Mental Health Services Administration, 2014). In addition, youth in foster care have had at least one, if not multiple, experiences of abusive, neglectful, and/or transient experiences with adults. Given that attachment serves as the foundation for trust and forming healthy relationships (Bowlby, 1969), many youth who have experienced foster care may find difficulty in trusting adults (Britner, Balcazar, Blechman, Blinn-Pike, & Larose, 2006). Using foster care alumni as interventionists or embedded in an intervention with videos may be more palatable for these young people.

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Several participants described their dislike for one-size-fits-all approaches. This corroborates previous qualitative work with foster care staff, administrators, and parents, who suggested that interventions should not only be tailored to the population but could benefit from utilizing technology (Braciszewski et al., 2014). While technology-based approaches have their limitations, there is significant potential for computer- and mobile phone–based programs for this vulnerable population. In addition to delivering evidence-based treatments with perfect reliability and fidelity, technology-based interventions can address many of the population-specific barriers noted above. First, measurement of substance use through computers and mobile phones may increase the likelihood of honest reporting through privacy and confidentiality (Kam & Chismar, 2005); this can dampen concerns about negative consequences for reported alcohol or drug use (Braciszewski et al., 2014). Second, trust issues are mitigated by eliminating the need for a human interventionist but may also increase the likelihood of seeking treatment in the future, if/when youth recognize the need for formal treatment. Third, youth in foster care often experience myriad placements and significant housing instability (Courtney et al., 2004). Technology-based interventions can be utilized at the user's discretion, regardless of location and time of day. Finally, these dynamic, adaptive interventions can be tailored to the needs of each individual, taking into account literacy issues, mental and physical health comorbidities, substance of choice, and preferred method of learning. Granted, such approaches are in their infancy, yet the possibilities are limitless.

Strengths of this study include incorporating the voice of the population of interest. Our sample—youth who have recently experienced foster care and would be eligible for a substance use intervention—offers a unique perspective on substance use interventions. It is our hope to improve substance use services within child welfare; thus, obtaining the view of individuals with lived experience will help augment any efforts to help those currently in care. Their experience with substance use, moreover, adds further validity to the building blocks of a successful intervention. While clinicians and researchers can offer evidence-based suggestions for intervention development, adding information from people actively involved in the behavior of interest allows for an important perspective that is often missed.

While this study offers insight into the successful development of future substance use interventions for youth in foster care, it is not without its limitations. First, youth were recruited from one urban area of New England and may differ in background and experiences from youth in other states. In addition, while participants were helpful in identifying the limitations of current treatments/interventions, there may be less consensus in informing what more effective approaches might concretely look like. It is easy to assume that such approaches should remove barriers identified by participants, yet addition by subtraction may not fully encapsulate a robust intervention structure. Although it would have been optimal to ask at least a subset of youth for reactions to our summary of findings, we did not have the opportunity to follow up with this hard-to-reach population. However, we found a consistency in the responses from both earlier and later interviews that offered support for the sense that respondents were candid and reporting generally agreed-upon understandings of factors that impeded or supported treatment seeking.

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Implications and Future Research

In addition to our excitement about pursuing technology-based interventions, we believe these results have several implications for child welfare practice. First, and perhaps most importantly, we strongly recommend continuing education courses and training on substance use for case managers, child welfare administrators, and foster parents. Youth in foster care are at heightened risk for substance misuse, yet the groups bound to their success are often unprepared to address such issues and can do so in ways that are harmful to these young people. Previous studies have indicated a strong relationship between maltreatment and a low perception of self (Appleyard et al., 2010). Thus, youth in foster care may have a heightened sensitivity to criticism and stigma-based scolding. Thankfully, upon receiving substance use training, case managers have been shown to reduce their negative attitudes toward substance use and increase their willingness to add substance-using young people to their caseloads (Amodeo, 2000; Amodeo & Fassler, 2000). Training on the identification of substance use problems and self-efficacy for working with substance using youth could also be extended to foster parents. Families are more willing to foster a young person with a substance use problem if they have received training in this area (Meyers et al., 2013). Given the myriad responsibilities that fall upon foster care staff, case managers, and foster parents, taking significant time away from work and other tasks to attend such trainings may prove difficult. Future research should investigate the most efficient methods of delivering trainings, including using web-based tools. Such trainings have high potential to increase the success of youth engaging in substance use treatment by introducing these services in a collaborative and nonjudgmental way.

Motivational interviewing (MI; Miller & Rollnick, 2013), in particular, is a method of communication that helps individuals resolve ambivalence about behavior change. MI is used across myriad health-care settings and populations and has been shown to yield promising results with respect to problematic substance use (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005). In many ways, MI and the TTM (Prochaska & DiClemente, 1992) are complementary, as MI is a method of conversation that is particularly effective at the beginning TTM stages of readiness for change (DiClemente & Velasquez, 2002). Thus, in addition to general substance use training, child welfare agencies should consider investment in MI training for their staff. Given its nonjudgmental stance, the use of MI is likely to improve relationships between youth and staff and strengthen the foundation from which to have conversations about behavior change. Training in MI may also help service engagement, as youth in care tend to report a small number of treatment visits (Leslie et al., 2000).

Second, early and routine screening of substance use and associated risk factors can help prevent substance use initiation and escalation. Such efforts are also likely to have an additive effect, reducing the likelihood of other negative outcomes associated with early initiation of alcohol and drug use. However, data collection cannot end at screening. Youth who endorse substance use should receive comprehensive follow-up assessments and placement into a level of care commensurate with their use. Research on substance use among youth in care has often been limited to being one of a host of outcomes being assessed within large studies. Thus, there have been no theoretically driven, longitudinal

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inquiries that focus solely on understanding substance use, mechanisms of initiation, use over time, and development of substance use disorders. Given the need to collect these data, child welfare agencies should partner with researchers toward a comprehensive effort to deliver healthier outcomes for this population.

In addition, states should create interagency alliances to prevent redundant work and promote data sharing, so that youth can be served properly and efficiently. Child welfare agencies and community mental health do not often have a way to connect, despite serving the same population. Despite this, child welfare agencies and service providers have indicated a strong desire for collaboration and cotraining (Kerns et al., 2014). Such an effort is particularly important for youth who are exiting care, as they are “handed off” from a child-based system to one for adults. Through grant-funded efforts (Substance Abuse and Mental Health Services Administration, 2016), many states are supporting multiagency transition-aged care systems that serve the unique needs of young people in this developmental period. These efforts would be especially beneficial for youth exiting foster care, so that they are not left to fend for themselves in the adult services world.

Finally, social support remains a strong predictor of recovery from substance misuse; yet, for many youth in care, this resource can be a reminder of rejection. Mentoring programs are highly popular among at-risk populations and can provide not only direct, instrumental support but also the skills required to build upon that foundation. Given the resiliency power associated with increased social support, future studies and efforts to augment clinical services will need to address robust approaches to building these resources with a population that may be ambivalent about such a process.

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Appendix

Focus Group Script

Instructions in italics; **script language in bold.**

Introduction

- Thank them for coming.
- Introduce the facilitators.
- Explain that this is a focus group to help the research team eventually design a program for reducing alcohol and drug use among young people leaving care. A focus group is a group discussion where we ask for people's opinions and experiences. We also hope to have some discussion among participants.
  - **We will ask about alcohol and drug use, in general, among your peers. We will NOT ask you about your experiences with alcohol and drug use. You may share these experiences with us if you would like.**
  - **We will use your experiences and opinions to help us design a program specifically for youth in foster care to reduce the harms that are associated with drinking and drug use.**
  - **You are the experts here. You are the only ones who can tell us about the experiences of youth in foster care and how to make the program interesting and useful to other youth in care like yourselves. You're helping us make something that will help future youth in your place.**
- **The goal is to finish this conversation in 90 min. In order to do that and to cover all the topics, we might need to shorten a discussion on one topic in order to move on to the next one.**
- **There are no right or wrong answers. Both positive and constructive comments are welcome.**
- **What questions do you have?**

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- Conduct informed consent, which involves going through the paperwork out loud.
- Cover focus group privacy expectations.
- **What questions do you have?**
- Turn on audio recorders.

Evoking their ideas for a program

- Explain why we're doing this; why we think it's important.
  - High substance use rates postexit;
  - High rates of homelessness postexit;
  - Long-term health consequences;
  - Difficulties with availability/engagement in services (i.e., sometimes there's nothing, sometimes there's nothing interesting).
- **If one of your friends wanted to avoid getting into trouble with alcohol/drugs.** … *(Remember, the intent of this section is NOT to collect detailed information about the participants' specific drinking or drug use habits. Rather we want to learn about the strategies that our program might employ to help future participants. Therefore, these are general questions about how other foster youth use alcohol/drugs. Remind them of this. OK if they talk about their own experiences, though.)*
  - **What would you do/say to them?**
  - **How would you communicate to each other?**
  - **How serious would it have to be in order to say something?**
  - *(If it hasn't come up already)* **Some people are ready to work on these issues, some aren't. What do you do with those different kinds of people? How do you reach them all?**
  - **What would motivate someone to cut down on drinking/drug use?**
- Things we need to cover if they don't come up with the questions above.
  - What/content (Probe what content/features would make it interesting);
    - (For example) **If you were going to design a program, what features would it have? What would the words/content/messaging look like? What topics would it cover?**
  - Where/location (Probe access/possible transportation issues);
    - (For example) **How would you deliver it? Would you go to a clinic? Come here to the office?**
  - How long/length (Probe time commitment);

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- (For example) **How long would it last? How often would you meet/interact?**

– Who/support (Probe possible supports/helpers/interventionists);

- (For example) **Would you be willing to interact with someone you identify? How do you feel about involving another youth in care? Your case manager? Mentor? Professionals?**

• *Don't forget to encourage interaction among participants, rather than just our questions with prompts like ….*

– **What do others think about X participant's comment?**

– **Do all of you feel that way?**

– **Have you had different experiences?**

– **I'm hearing a lot about X. What do people think about that?**