Introduction

The research is clear that children who are involved in the child welfare system due to maltreatment or neglect and exposed to the often co-occurring parental issues of substance abuse, mental illness, and domestic violence, do not fare well compared to their peers who are not exposed to such adversities. Each child’s mental health is affected differently and each developmental stage of the child’s life may be fraught with challenges in learning, pro-social behavior, relationships, and mental health.

Approximately 80 percent of children in foster care have been identified as having significant mental health problems compared to 22 percent among children in the general U.S. population. However, only 23 percent of children in foster care for 12 months have received mental health services.¹ An estimated 70 to 85 percent of children in the child welfare system who are identified as needing mental health services do not receive services, and that number is higher for children under three who generally are not screened for mental health needs and rarely receive mental health services.² One study estimated that even when screened for mental health services only 2 percent of 1.5 to 2 year-olds and 13 percent of 2 to 5 year-olds received services.³

Experts recommend using a trauma-informed lens when considering the mental health needs of children in foster care. Because trauma symptoms and mental health symptoms frequently overlap, Griffin et al. recommend that all youth in child welfare be assessed for trauma events and symptoms and that a “clinician not diagnose a youth in child welfare without first addressing the impact of trauma” (p. 87).⁴ From a trauma perspective, this paper provides a review of the literature regarding the mental health needs of three populations of youth who are involved with the child welfare system: 1) Children under the Age of Five; 2) Children Age Six to Eleven; and 3) Adolescents Age Twelve to Eighteen. In addition, it provides a brief overview of 1) the intersection between foster care and the commercial sexual exploitation of children and 2) LGBTQ foster care youth.

Mental Health Needs of Young Children from Birth to Five

In Florida, 2015, nearly half of the foster care population was comprised of young children: less than 1 year totaled 9 percent (2,035) and 1 – 5 years totaled 40 percent (8,880).⁵ While the overall foster care population has decreased nationally in recent years, the population of children five and under has increased by 42 percent between 2010 and 2015, with children under one accounting for the largest percentage of the increase.⁶

Infants and young children are a particularly vulnerable population. They experience the highest rates of abuse and neglect and suffer the most injuries and fatalities.⁷ Abuse and neglect interfere with the primary developmental goal of young children, which is to form a secure attachment to a primary caregiver. From a developmental perspective, the lack of consistent, responsive, and nurturing care results in an infant whose survival instinct for proximity is thwarted.

Bowlby⁸ contends that without a secure attachment to a primary caregiver, a child’s ability to develop effective coping strategies in stressful situations is compromised. As a result, the child is likely to struggle with regulation of emotions. A persistent lack of nurturing care or disruption of care can result in significant mental health disorders.

Reactive Attachment Disorder (RAD) is one such disorder. The DSM-5⁹ separates attachment disorders into two types: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder (DSED). Both disorders manifest before age five. RAD is characterized in the DSM-5 as a consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers.
Children who meet criteria for RAD rarely or minimally seek comfort from caregivers when distressed; these children rarely or minimally respond to comfort when distressed, and may have episodes of unexplained irritability, sadness or tearfulness, and limited expressions of positive affect or joy. DSED, on the other hand, is characterized by a pattern of behavior in which a child actively approaches and interacts with unfamiliar adults in an impulsive, incautious, and overfamiliar way. Symptoms include lack of reticence in approaching and interacting with unfamiliar adults, overly familiar verbal or physical behaviors such as hugging strangers, or sitting on the laps of unfamiliar adults, willingness to approach a complete stranger for comfort or food, to be picked up or to receive a toy, and diminished or absent checking back with adult caretakers when in unfamiliar situations. Other conditions can be associated with child maltreatment and RAD or DSED, including defiant behavior, refusal to cooperate, pervasive anger and resentment, cognitive delays, language delays, difficulties in social settings, and academic difficulties.

While there is limited research on the prevalence of RAD, authors like Allen note that the best available studies suggest that few children, even those with histories of severe neglect, meet criteria for RAD and DSED. At the same time, clinicians commonly diagnose RAD in children with histories of early maltreatment and subsequent externalizing behaviors suggesting significant problems with diagnostic assessment in early childhood and a lack of clinical precision. Part of the problem is that attachment refers to the child-caregiver relationship and nosologies like DSM-V are used to diagnose disorders in individuals. Chaffin, et. al concur that children with trauma histories rooted in pathogenic care should not automatically be assumed to have an attachment disorder. Practitioners are encouraged to view attachment issues as complex transactional processes involving genetics and environment and to seek further training in diagnostic assessment in early childhood.

Early intervention with evidence-based treatment offers the most promising approach to restoring a child’s ability to find safety and comfort in relationship to a trusted adult. Maltreated children also display deficits in emotional knowledge, a key developmental process that occurs in early childhood. Children’s emotional knowledge generally begins with parental mirroring of the infant’s emotional state. As verbal ability increases so does an understanding of both one’s own and other’s emotional expressions. According to Harden and Morrison, recognizing emotional expressions and cues are necessary for successful social interactions and interpersonal relationships and may be instrumental in developing emotional regulation. They state that maltreated children are less able to correctly label emotional expression. Furthermore, maltreated children often display language delays, and language skills are strongly associated with an ability to accurately identify emotional expression. They recommend foster parents of young children receive in-service training that 1) focuses on developmental factors such as attachment and emotional vocabulary; 2) stresses the importance of emotional responsiveness to the young children in their care; and 3) stimulates the children’s verbal ability, especially their emotional vocabulary. The authors conclude that timely intervention and developmentally sensitive care by foster parents can somewhat ameliorate a child’s early adversity and improve developmental outcomes.

The lack of a secure attachment figure can disrupt an infant’s neurodevelopment and can result in lifelong impairment. For example, infants who suffer trauma in the first year of life may develop an insecure-disorganized/disoriented or “Type D” attachment style. Infants with this attachment style display confused and contradictory proximity seeking to caregivers, a low tolerance for stress, and an impaired regulatory system that quickly decompensates under stress. It is estimated that 80 percent of maltreated children display a Type D pattern of attachment. According to the National Scientific Council on the Developing Child, moderate, short-lived stress can be positive in an infant’s life as the caring adults help him or her to manage these normal life stressors thus promoting the child’s sense of mastery. However, without the support of a warm and caring adult, stress can become toxic. Toxic stress refers to the “…prolonged activation of the body’s stress management system” (p. 2). The toxic stress responses that occur in infancy can adversely affect brain development when regions of the brain involving fear, anxiety and impulsive responses overproduce neural connections and regions involving reasoning, planning, and behavioral control under-produce neural connections. The neurobehavioral and neuro-hormonal responses to toxic stress can have a lifelong adverse effect on memory, learning, and behavior. Furthermore, structural brain changes in infancy can later manifest in negative emotions, maladaptive behaviors, and conflictual attachments.

Early adversity, toxic stress, and traumatic events put foster children at higher risk for developmental delays. Approximately 80 percent of foster care children have an identified developmental delay compared to 10 – 15 percent of children in the general population. In the same study, developmental screening of foster children under the age of six identified 46 percent (N = 167) of the population with potential developmental delays. Delays were noted most frequently in the domains of receptive language, behavior, self-help, language and articulation, and social/emotional. According to Merritt and Klein, language development is particularly affected by maltreatment, especially neglect. They note that language is learned in the context of early interactions between the infant and the primary caregivers. When these interactions are compromised by abuse and neglect, the young child often demonstrates delays in receptive and expressive language that are two or more standard deviations below the norm. Language competency is essential for school readiness and is strongly associated with literacy. Furthermore, language delays negatively affect social-emotional development and the ability to sustain positive relationships. Difficulties in using one’s words to negotiate relationships may lead the child to “acting out” behaviors that increase the risk for negative social interactions. Merritt and Klein state that 70 percent of children with language delays have co-morbid behavior problems and that “attention-deficit and hyperactivity disorder, conduct disorder, oppositional defiant disorder, depression and anxiety are all highly correlated with language delays” (p. 187).

The National Child Traumatic Stress Network (NCTSN) state that many of the mental health disorders experienced by foster children are rooted in trauma-related events that occurred prior to removal, the removal itself, and experiences post-removal. Greeen et al. note that 70.4 percent (N = 2,251) of the foster care sample in their study were exposed to two or more traumas. A history of complex traumas increases the risk of an internalizing
mood disorder by 60 percent, severe posttraumatic stress symptoms by 53.2 percent, and at least one clinical diagnosis by 21.3 percent. Furthermore, there is evidence that preschool children in foster care are at elevated risk for PTSD and should be screened for this upon entry into the child welfare system. NCTSN recommends all children, including the very young (under 5), be screened with tools such as the UCLA Posttraumatic Stress Disorder-Reaction Index, the Trauma History Profile, and the Child Behavior Checklist. Yet, as many studies have found, relatively few children are screened for trauma exposure or receive trauma-informed services.

In summary, young children in foster care are at high risk for mental health disorders. Children who are abused before age five have a greater likelihood of experiencing internalizing and externalizing disorders than children whose abuse occurred after age five. This is due in large part to the critical role that attachment plays in healthy development. Maltreated infants and young children are at risk for disorders such as:

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Defiant behavior, refusal to cooperate, pervasive anger and resentment, and conduct disorder
- Cognitive delays, language delays, difficulties in social settings, and academic difficulties
- Deficits in emotional knowledge that can result in unsuccessful social interactions, interpersonal relationships, and emotional regulation.
- Toxic stress responses that adversely affect brain development and have long-term adverse effects on memory, learning, and behavior.
- Structural brain changes in infancy that later manifest in negative emotions, maladaptive behaviors, and conflictual attachments
- Low stress tolerance
- Developmental delays especially receptive language, behavior, self-help, language and articulation, and social/emotional delays
- Language delays that impede school readiness and literacy skills, negatively affect social-emotional development and increase co-morbid behavior problems such as attention-deficit and hyperactivity disorder, conduct disorder, oppositional defiant disorder, depression, and anxiety
- Complex trauma that increases internalizing mood disorders, severe posttraumatic stress symptoms, and at least one clinical diagnosis.

Mental Health Needs of Children Age Six to Eleven

There is limited research available on the mental health needs of children in this age range, and most of the research relates to the impact of mental health disorders on school performance. Neilheiser reports that approximately 21 percent of the nearly half-million children in foster care are between the ages of 6 – 10 years. Academically, foster children are at risk for poor outcomes. They are 44 percent less likely than their non-foster peers to graduate from high school. From the earliest school years, foster children struggle with reading, writing, and mathematics with scores that are 20 percent lower than their peers. Furthermore, their academic success is negatively impacted by clinically significant behavioral problems such as antisocial activity, withdrawal, and depression. School problems are exacerbated when children move homes and schools, and placement instability increases each year a child stays in the foster care system.

According to Erikson, school success is critical for this age when formalized learning overtakes playful learning, and the child demonstrates industry through the skilful use of tools valued by adults. This is the foundational process for eventual work and with it the capacity to parent and care for others. If the child’s industry is rewarded by encouragement and approbation, she will find a sense of competence. The developmental danger is that the child will lack confidence in her abilities to master tools effectively or to find acceptance among her peers. This can lead to withdrawal and isolation; she may feel resigned to mediocrity, which results in the core pathology of inertia. Unfortunately, many foster children have great difficulty mastering the skills necessary for school success.

The developmental, emotional, and cognitive functioning of young foster children pose problems for meeting the transitional demands of elementary school. One study notes that traumatic experiences impair socio-emotional functioning, which results in impaired emotional regulation, hypervigilance, hyperactivity, impulsiveness, apathy, and sleep disorders. Foster children also demonstrate decreased prosocial behavior and increased peer problems. Maltreatment can result in elevated risk for internalizing and externalizing disorders. When these disorders are displayed early in a child’s life (under 5), they tend to carry over into childhood and adolescence. The neurobiological effects of trauma may result in delayed cognitive development often expressed by a decrease in fine and gross motor skills and language delays. These issues often result in poor school performance such that approximately 25 to 52 percent of foster care children receive special education services compared to 13 percent of the general child population. More than 40 percent of foster care children placed in special education classes were referred for severe attention difficulties, poor impulse control, and aggressive behaviors.

Yoon, Yoon, Wang, Tebben, Lee and Pei define internalizing behavior problems as “inward-directed feelings and include symptoms of depression, anxiety, withdrawal, and somatic complaints, whereas externalizing behavior problems refer to acting-out behaviors directed towards others, such as aggression and rule-breaking behaviors” (p. 455). The majority of studies show internalizing and externalizing behaviors to be comorbid. Exposure to intimate partner violence (IPV), caregivers’ mental health problems, including depression and anxiety, and caregivers’ substance use increase a young child’s display of internalizing and externalizing behavior problems. Out-of-home placement for children under six also increases the presence of behavioral problems, and a caregiver-child insecure attachment pattern is significantly associated with child internalizing and externalizing behavior. Neglect had the most significant impact on the development of these disorders, as did exposure to IPV, and caregiver mental health problems. Foster parent stress strongly predicts a child’s internalizing and externalizing behaviors, with a possible bidirectional relationship between caregiver stress and child’s behavior problems. Without intervention, these behavioral disorders will persist into childhood and affect interpersonal and school functioning.
Positive school engagement is seen as a protective factor that predicts better academic achievement, grades, and standardized test scores. It also reduces the rate of drug usage and initiation of alcohol use.34 Children in foster care age 7 to 12 years who reported feeling supported by their classmates (affective engagement) displayed less engagement in delinquent and self-destructive behaviors six years later. Because non-maltreated children from low-SES backgrounds face similar school challenges and outcomes as foster children, one study compared the two groups on multiple dimensions of school engagement.31 Foster children had poorer affective and cognitive engagement than the comparison group “suggesting detrimental effects of a history of maltreatment and foster care independent of the effects of low SES” (p. 2208). The young age of school disengagement is worrisome as it robustly predicts negative long-term outcomes such as lower academic competence and increased risk behaviors in later middle school and increased dropout rates in high school.

Likewise, early school adjustment predicts school and psychosocial adjustments across later elementary and middle school.36 Early language and reading abilities predict positive achievement in reading and math 9 years later. Whereas, early academic struggles in language and reading predict increasingly problematic academic and social-emotional functioning. Approximately 46 percent of foster children under 7 face literacy challenges and about 50 percent of adults who age out of the foster care system read at a seventh grade level.37

Pears, Fisher, Bruce, Kim, and Yoerger38 state that two mechanisms leave foster children vulnerable to poor school adjustment: inhibitory control and caregiver involvement. Inhibitory control refers to the child’s ability to voluntarily inhibit or regulate attentional or behavioral responses. Disruptions in early caregiving or caregivers negatively affect inhibitory control as does punitive parenting and maltreatment. Preschool positive inhibitory control has been linked to improved school performance in first grade. As such, it might provide a link between early experiences and school outcomes. Likewise, caregiver involvement is a significant predictor of academic achievement. Foster parents have barriers to school involvement such as frequent placement disruptions and limited knowledge of the foster child’s academic and social-emotional functioning. Overall, foster parent school involvement was less than biological parents of non-maltreated children. Study findings demonstrated that foster children’s level of risk for poor school adjustment can be identified at school entry. The authors point out that the inhibitory control critical for school success is amenable to intervention. The skills necessary for inhibitory control can be taught to young children.

According to Fantuzzo, Perlman, and Dobbins, poverty is the most common co-occurring social risk associated with child maltreatment, with co-occurrence ranging from 58 to 81 percent.39 Neglect is more closely associated to poverty than other forms of maltreatment. It can be difficult to disentangle the effects of poverty and maltreatment on school performance. Their study controlled for multiple risk factors, including poverty, and found that children neglected prior to kindergarten were at increased risk for poor performance in reading, language, and science during the second grade. Compared to their peers, neglected pre-kindergartners were 31 percent more likely to have a poor outcome on a standardized reading assessment; 42 percent more likely to have poor language outcomes; and 35 percent more likely to have poor science outcomes. Academic achievement was not significantly associated with physical abuse.

Scarborough and McCrae40 looked at the relationship between maltreatment in infancy and toddlerhood and school-age educational outcomes. Using the National Study of Child and Adolescent Well-Being, they found that infant/toddler (0 – 36 months) baseline data predicted school-based outcomes as indicated by special education placement at wave 5 (5 – 8 years-old). The older children with a reported IEP were more likely to be male, have poor or fair physical health at baseline, have low language scores at baseline, and live in households below the federal poverty line at baseline. Language delays in young children are an early marker of school-age special education placement. Poverty was the only caregiver characteristic significantly associated with special education placement. The authors recommend that:

1. child welfare systems recognize the importance of early developmental services based on child well-being screening that includes scores on developmental measures and other early risk markers such as being male, living in poverty, and fair or poor health status
2. children at risk be provided with Early Head Start or another quality preschool program. Young children most at risk for later school failure have a window of opportunity for improved outcomes through targeted intervention when it matters most.

Disability and maltreatment share a complex bidirectional relationship. Haight et al. note that disabled children are at increased risk for maltreatment and maltreated children are at increased risk for a disability.41 The authors highlight the special needs of children with “hidden disabilities” such as mild cognition or behavioral problems that are often overlooked by school personnel. These children struggle with interpersonal relationships, have difficulty learning to read, write, or calculate, and often display inappropriate behaviors or emotional responses. Yet, their behavior may be misinterpreted as “disobedience, disrespect or laziness” (p. 421). Early screening can help to identify mild disabilities among foster care children.

In another school study, 32 percent (N = 3309) of the children with maltreatment histories were eligible for special education. Of those children, 73 percent had mild cognitive or behavioral disabilities such as specific learning disabilities (33%), emotional/behavioral disorders (27%), health impairments including ADHD (16%), speech and language impairments (11%), and Autism Spectrum Disorders, high functioning (7%). Interviews with school personnel highlighted other reasons for maltreated children’s poor school performance. They cited unmet mental health needs as contributing to the children’s school disengagement. Most notably the children had difficulty developing and maintaining relationships with both peers and adults. Histories of poor attachment were attributed to the children’s reluctance to establish relationships with teachers and other caring adults.42 Trauma informed interventions that address attachment issues may help a child to engage in healthy peer and teacher relationships that, in turn, may contribute to improved academic results and prosocial behaviors.

Children with disabilities are at greater risk for maltreatment. A study in Minnesota examined the administrative records of 6,270 children with substantiated cases of abuse and neglect. The findings showed the prevalence rates were between 1.7 to 3.4 times higher for disabled children to be maltreated than their peers without disabilities.43 Neglect was the primary form of maltreatment, but children with disabilities were more likely to experience all forms of maltreatment and multiple types of maltreatment than their nondisabled peers. Additionally, the
authors found that 28 percent of the children over age 5 with substantiated maltreatment also had a reported disability code. Children with a disability code were placed in foster care 64 percent of the time compared to 49 percent of the time for children without a disability. The most common disability codes for children over 5 were emotional disturbance (43%), multiple disabilities (11%), and developmental disabilities (9%). The authors conclude that mandatory training on childhood disabilities be provided to child welfare workers and foster parents and that inter-professional collaboration take place to provide the quality of services required by Title II of the American with Disabilities Act of 1990.

As noted in the previous study, emotional disturbance (ED) is a commonly identified disability among maltreated children. One study found that “nearly half of the children in both foster care and special education have an ED as their primary disability, compared to slightly over 10% of children in special education only and not in foster care (p. 273).” Children with an ED are at risk for poor outcomes such as high dropout rates, serious mental health issues, substance abuse, and juvenile justice involvement. Maltreated children are at risk for similar outcomes. Maltreated children in foster care who were diagnosed with an emotional disturbance experienced significantly more academic and behavioral problems than students in the comparison groups. For children diagnosed with an ED, children in the child welfare system were more often identified as having problems with adaptive and social behaviors, mental health, speech and language, and health issues. Mental health ER visits and later delinquency were also more prevalent among youth with emotional disturbances. It is important to note that black children are overrepresented in the child welfare population and in the emotionally disturbed population as well. Black children were 1.92 times more likely to be identified as emotionally disturbed than white children and poverty alone could not explain the finding. Given the serious outcomes for foster youth diagnosed with an ED, race and cultural competence should play a critical role in the development of effective interventions. Interventions should focus not only on the student but on the family system as well. The authors suggest offering families evidence-based programs such as Parent Child Interaction Therapy and the Incredible Years, but note that research findings indicate that most biological or foster families are not receiving specialized parent training for children with high-risk behavior problems.

Research indicates that foster children fare poorly in their elementary school years. Their performance may be dictated by earlier trauma and failed developmental milestones such as healthy attachment to a caring adult and by substandard environmental conditions such as poverty and high-crime neighborhoods. Without appropriate intervention, early deprivation and maltreatment continue to exert their influence in the school-aged child’s cognitive and behavioral capacities. Foster children in this age range are at increased risk for:

- Internalizing and externalizing behavioral disorders such as antisocial and acting-out behaviors, withdrawal, and depression
- Impaired social-emotional functioning displayed as poor emotional regulation, hyperactivity, impulsiveness, and apathy
- Decreased prosocial behavior and difficulty developing and maintaining peer relationships
- Special education placement for severe attention difficulties, poor impulse control, aggression, and severe emotional disturbance
- School disengagement which is an indicator of increased high-risk behaviors
- Decreased inhibitory control—difficulty regulating attentional and behavioral responses
- Specific learning disability
- ADHD and other health related disorders
- Severe emotional disturbance
- Increased mental health problems
- Attachment disorders

**Mental Health Needs of Adolescents Age Twelve to Eighteen**

According to the Kids Count data center, in 2015, 27 percent of children in Florida’s foster care system were between the ages of 11-20 and approximately 5,762 children were between the ages of 12-17. Studies indicate that adolescents in foster care face many developmental, mental health, and behavioral challenges. These findings may reflect the increased exposure to adverse childhood experiences (ACEs) lived by many foster children. In a study based on a nationally representative dataset of foster youth ages 0 to 17, the researchers found that foster children faced more ACEs than the comparison group of children living in poverty in single mother households (i.e., a group of children who are also at risk for high ACEs). Likewise, children in foster care were exposed to ACEs at a greater frequency than children not in foster care. For example, foster youth were more likely than non-foster youth to experience higher incidents of parental divorce (45.4% vs. 19.6%), parental death (11.5% vs. 2%), parental incarceration (40.1% vs. 6.4%), parental abuse (34.2% vs. 6.9%), violence exposure (31.1% vs. 8.2%), household member mental illness (33.7% vs. 8%), and household member substance abuse (53.8% vs. 9.9%).

There is a link between ACEs and a child’s health and well-being. Without intervention, a child’s well-being may be compromised across the life span.

Developmentally, adolescence is the time to consolidate one’s identity. According to Erikson, the search for identity leads youth to experiment with various roles, beliefs, circles of friends, social roles, and romantic friendships. Unlike previous stages, which primarily occurred within the family, adolescents’ pursuit for identity occurs among peers who support one another in the search for a meaningful self. The youth who fails to find belonging among his peers is excluded from the social context wherein identify forms and may find himself experiencing role confusion and social isolation. However, Erikson believes adolescence offers an opportunity to heal the psychic wounds of childhood as youth refight many battles of earlier years in order to find resolution and the self-efficacy needed to consolidate their identities and successfully enter young adulthood.

As with younger foster children, foster teens face many mental health challenges. Some of the negative mental health outcomes are rooted in earlier experiences of abuse and neglect and some are unique to the developmental needs of adolescence. Bederman-Gardner et al. looked at the role of placement instability
in adolescents’ risks for poor mental health and attachment insecurities. The study compared 17-year-old foster youth (N = 146) with 17-year-old non-foster youth (N = 86). The comparison group was drawn from high schools serving low income at-risk youth. Poor mental health was measured by scores on a PTSD self-report measure and a depression/anxiety self-report measure. Attachment anxiety and avoidance was measured by scores on the Experiences in Close Relationships—Short Form, a self-report measure. The findings indicated that increased placement instability, defined as a higher number of homes lived in and schools attended, predicted more severe PTSD symptoms in foster youth but not non-foster youth. Instability did not predict worse anxiety/depression or attachment insecurity. Furthermore, the study showed that “residential and school instability is a stronger associate than foster care status itself of mental health difficulties, specifically symptoms of PTSD” (p. 166). This finding could be related to the developmental need of adolescents to foster and maintain close friendships and social networks. Residential and school moves disrupt this normative phase of adolescent development.

According to Webster, Barth, and Needell, approximately 52 percent of foster children experience three or more moves in their first year of care, and the longer the children are in care the more they will experience placement moves. The more moves experienced within the first year of care significantly increased the likelihood of subsequent moves, such that children who were moved three or more times in year one were 65 percent more likely to be moved three or more times during the remainder of their time in foster care. Boys were 33 percent more likely than girls to experience placement instability. The role of placement instability and its unique effect on boys’ engagement in delinquency was found in a study by Ryan and Testa. Using administrative data from the Illinois Department of Children and Family Services, they found that delinquency rates of all child welfare involved youth between the ages of 10 and 16 was 42 percent higher than the general population, and that children in foster care were more than double the risk of delinquency than children not in substitute care. This held true for both girls and boys. The risk of multiple placements on delinquency, however, differed by gender. For females, placement itself increased the risk of delinquency (6% compared to 3% for girls who remained in the home), but for males it was placement instability rather than placement itself that increased the risk for delinquency (23% compared to 11% for boys who remained in the home). The authors comment that multiple placements in substitute care may deplete a child’s stock of social capital, the “durable relationships of commitment, trust and obligation that bind people together” (p. 229), which weakens the social attachments and social controls that prove to be protective factors against engaging in delinquent behavior. Overall, the research suggests emphasizing policies, interventions, and services that increase placement stability to promote better child outcomes, particularly for adolescent boys.

Older foster youth often struggle with affect dysregulation (AD): heightened reactivity to strong emotions, difficulty calming down once upset, and mood instability. The authors state that acquiring emotional regulation is a normal part of child development, but adverse experiences have been shown to disrupt the normal developmental pathway. Difficulties with emotion or affect regulation is linked to a wide variety of mental illnesses such as depression, anxiety, ADHD, eating disorders, and borderline personality disorders. In the absence of affect regulation, youth may use maladaptive strategies such as substance abuse, binge eating, risky sex, social withdrawal, and self-mutilation in an effort to regulate their intense emotions. To assess the risk and impact of AD among foster youth, the study measured the symptoms of affect disorder, affect instability, and affect skills deficits, and assessed for mental disorders using the DSM-IV among 17-year-old foster youth (N = 325) and then followed them for two years. The majority of study participants displayed clinical levels of affect disorder. Affect instability and affect skills deficits were correlated to diagnoses of depression, ADHD, and disruptive behavioral disorders. Follow-up with youth age 19 that had been identified with AD had mixed results. The anticipated associations of AD with high-risk sex or substance abuse were unfounded; however, AD skill deficits were associated with higher high school dropout rates and arrests in early adulthood. The association of AD with disruptive behavioral disorders may partially explain the increased likelihood of arrest. Furthermore, the study’s results suggested that “affect skills deficits are an important correlate of which youth in foster care are treated with psychotropic medications and are hospitalized or placed in congregate care treatment facilities” (p. 218). The recommendation is to introduce youth to behavioral interventions that focus on building affect regulation skills, which may reduce the need for psychotropic intervention and restrictive environments.

Exposure to multiple traumas is a strong predictor of mental health problems among foster youth. Using a nationally representative sample of foster youth, Wojciak, McWey and Helfrich studied the increased risk for internalizing symptoms such as depression, anxiety, withdrawal, and somatic complaints among foster children and examined the impact sibling relationships may have on internalizing symptoms. An estimated 33 percent of foster children had clinically significant internalizing problems with the potential to develop into mood and anxiety disorders, drug use, and suicidality. Adolescents in foster care were 37 percent more likely to demonstrate clinically significant internalizing disorders compared to other age groups. The authors hypothesized that “positive perceptions of sibling relationships would serve as a mediator between the negative effects of experiencing trauma and internalizing symptoms” (p. 1074). The results supported the hypothesis: positive perceptions of the sibling relationship, having a desire for more contact, and seeing the sibling more often mediated the relationship between trauma and internalizing problems. The recommendations were to examine further the protective factor of sibling relationships and to determine the potential of quality relationships to improve the mental health outcomes of foster youth, especially adolescents.

Foster youth are also at greater risk of externalizing behavioral problems such as substance abuse, aggression, conduct disorder, and delinquency than non-foster youth. Farruggia and Germo note that maltreatment and family conflict exacerbate problem behaviors; whereas, positive relationships with foster family and peers are associated with lower levels of aggression and substance use. The study examined whether the moderating effect of relationship-quality on youth involvement in problem behavior differed by gender. Problem behaviors were defined as the number of DSM-IV Axis I diagnoses (conduct disorder), aggression, and substance abuse. The findings revealed very few gender differences but generally supported the positive role of perceived warmth and acceptance from biological parents,
foster parents and peers on behavior. Youth residing in high-risk communities who perceived greater warmth and acceptance from foster parents displayed lower levels of problem behaviors, and youth in low-risk communities who perceived higher levels of warmth and acceptance from peers demonstrated lower levels of involvement in problem behaviors. However, youth in high-risk communities with the same perceived levels of warmth and acceptance from peers was associated with an increase in problem behaviors. The authors state that high-risk violent neighborhoods may reduce the protective utility of peer relationships. Based on the findings, they suggest that interventions with older youth should promote positive social relationships with caregivers and peers. Placement stability with adolescents is especially important since it supports social relationships, which are an essential part of adolescent adjustment. Placement decisions should consider neighborhood characteristics, since living in a high-crime community may increase problem behavior, particularly for at-risk adolescents of complex trauma experienced by foster youth. The authors recommend that young parents are offered trauma-informed therapeutic interventions to heal past traumas, enhance the parent-child relationship, and address the intergenerational cycle of maltreatment. Furthermore, child victims of sexual assault (CSA) are at increased risk of teen pregnancy. In one meta-analysis, women with a history of CSA were more than twice as likely to have become pregnant during adolescence than the comparison group of women without CSA histories. This finding supports the need for trauma-informed interventions.

Suicide
Suicide is the second leading cause of death for 10-24 year olds. Seventeen percent of adolescents have reported suicidal ideation, a precursor to suicide attempts in more than a third of adolescents. Prior attempts are a key risk factor since youth who die by suicide were sixteen times more likely to have made prior suicide attempts. The authors of this study remark on the paucity of suicide research for foster youth, an at-risk population. For example, adolescents with psychiatric disorders are at increased risk for suicide attempts and approximately 50 percent of foster youth have a DSM diagnosis. The systematic review compared the prevalence rates of suicidal ideation, suicide attempts and suicide in youth placed in care to youth in non-care. The findings were varied. Foster youth were more than three times as likely to attempt suicide, but no differences were found in suicidal ideation or suicide among foster and non-foster youth. The increase in suicide attempts is worrisome, however, since it is a prime indicator of future attempts and the possibly of successful suicides. The authors note that the results should be read with caution since there were so few studies included in the review. They state that future research is needed on suicide-related outcomes for this high-risk population.

Teen Pregnancy
Teen pregnancy for foster youth is two to three times higher than the national average of 22.3 pregnancies per 1000 girls aged 15-19. In one sample, 33 percent of girls in care had been pregnant at least once by age 17, and 71 percent of young women reported having been pregnant by age 21. Sixty-two percent of those who had ever been pregnant, had been pregnant more than once. In the comparison sample of non-foster young women, 33 percent had ever been pregnant by age 21 and the majority had been pregnant only once. Teen parenthood in general is associated with premature birth, low birth weight, death during infancy, and overrepresentation in the child welfare system. Children born to foster youth face a higher risk for experiencing maltreatment. Studies found that 22 to 29 percent of parenting former foster youth had been investigated for child abuse or neglect, and in approximately 11 percent of the cases the children were removed from their parents’ custody. According to Shelbe et al., the data on foster mothers’ parenting suggested the intergenerational transmission of child maltreatment. This can be explained, in part, by the frequently observed rates of parental substance abuse disorders than non-foster youth. The authors note that parental substance abuse is a factor in approximately 75 percent of foster care placements, and children of a substance abusing parent are at increased risk for later substance abuse. Using data from the Communities That Care Youth Survey, the study examined
foster (N = 1442) and non-foster youth (N = 282,826) attitudes and behaviors toward alcohol, tobacco, and other drugs. The mean age of respondents was 14.3 years. The findings showed that foster youth were more likely to have used all of the drugs listed on the survey and three times more likely to have used methamphetamine and four times more likely to have used heroin in the past 30 days than non-foster youth. A moderate difference was found for lifetime use. The use of alcohol between the groups was not significantly different. Youth attitudes toward drugs were similar except that foster youth were twice as likely to believe they would smoke cigarettes and marijuana when they were adults. Females in foster care appeared to be more likely to engage in substance abuse behaviors.

Females in foster care appear to be at greater risk for dating violence than females in the general population, although the extent of the risk remains unclear. A study by Jonson-Reid, Scott, McMillen and Edmond66 was conducted with 339 foster youth age 17. Approximately 18 percent of the sample reported a history of dating violence, 8 percent reported being a perpetrator, and 6 percent reported being both a victim and perpetrator. Youth who were white, female, victims of sexual abuse, met the criteria for PTSD or depression, and those who reported drug or poly-substance use were more likely to be victims of dating violence. Alcohol and drug use were associated with being perpetrators of dating violence. There was a significant association with a history of sexual abuse or a history of more than one type of maltreatment and dating violence victimization. For those experiencing dating violence, fifty-four percent of victims remained in the relationship. This rate is four times higher than a study on dating violence with a high school population. The authors pointed out that the majority of the sample did not experience dating violence, but just using the study’s measure of physical or sexual harm (about 6 percent) indicated a higher rate of dating violence among foster youth than the National Crime Victimization Survey rate of 1.7 percent for girls and less than 1 percent for boys in the general population.

Although the number of adolescents smoking cigarettes has steadily declined, the risk of smoking among vulnerable populations remains high.69 Foster youth tend to smoke more than youth in the general population, with 30 to 60 percent reporting lifetime smoking and 10 to 60 percent reporting current smoking compared to 39 percent lifetime smoking and 15 percent current smoking among adolescents in the general population. The study by Shpiegel, Sussman, Sherman and El Shahawy examined gender-based foster youth smoking habits (N = 1121).70 They found that girls and boys age at initiation was similar (12.4 years) as was the rate of lifetime and current smoking. Running away increased lifetime smoking by over 200 percent for both boys and girls. However, for boys, older age and placement in group home or residential treatment facility increased smoking by 200 percent compared to boys in non-relative foster homes. African American race lowered the smoking risk for boys by 70 percent compared to non-Hispanic whites. For girls, sexual minority status increased the risk of current smoking by 200 percent compared to heterosexual girls. African American race decreased the risk of smoking by 60 percent, sexual victimization increased risk by 90 percent, and each additional victimization increased the risk by 13 percent. The authors note that as youth smoking in the general population continues to decrease the foster care smoking rates are remaining stable. They recommend that interventions start young and address gender-based risk factors. Frequent screening of high-risk youth, easily accessible cessation programs, and alternative methods to manage internal distress may also help to reduce smoking among foster care adolescents.

Crossland and Dunlap71 examined the frequent occurrence of running away by foster youth. Foster youth are twice as likely to run away than youth in the general population. In a survey of runaway shelters, it was reported that 25 percent of youth came directly from a foster or group home and 38 percent had been in foster care during the previous year. The authors noted the increased risks of runaway youth for drug and alcohol exposure, criminal and sexual victimization, sexually transmitted infections, sexual exploitation, and arrest and/or incarceration. Females had a higher incidence of running away than males, and 90 percent of runners were at least 12-years-old. Other risk factors included placement instability, mental health diagnoses, substance abuse problems, residential facility placements, and the first several months of a foster care placement. Generally, youth were running to something like family, friends, and preferred activities or running away from something like unacceptable caregivers or abusive situations. Many neglected and maltreated youth were raised in environments that offered little structure which may make it difficult for foster youth to adjust to the rules of a group or foster home. Running away returned the child’s sense of personal control and freedom. The authors recommended further research focus on interventions such as behavioral analysis that determines a young person’s motivation for running and develops a plan to “improve individual quality of life indicators (e.g., physical and mental health, education, living situation, employment, relationships, social supports) by altering environmental arrangements as needed and by teaching and reinforcing desirable behaviors” (p. 1703).

Commercially Sexually Exploited Children in Foster Care

An estimated 200,000 minors are sexually exploited annually in the U.S., although the true prevalence of commercially sexually exploited children (CSEC) is unknown due to the numerous methodological limitations, multiple definitions, hidden nature of the crime, and the young person’s reluctance to seek support, unwillingness to expose the perpetrator, or seeing themselves as a crime victim.72,73 The reported numbers are most likely an undercount of actual child victims. The average age of entry into child sex trafficking is between 12 and 14 years of age.74 Studies have identified foster youth, especially runaway youth, as particularly at risk for sexual exploitation. Traffickers know that foster children’s histories of trauma, limited social support, and unmet need for family leave them more susceptible to manipulation.75 According to Speckman,76 the FBI reported that 60 percent of minor sex trafficking victims in 2013 were identified as living in foster or group homes. Likewise, the National Center on Missing and Exploited Children estimated that 60 percent of CSEC had been in the foster care system. The youth may be approached by traffickers while living in foster or group homes or when on runaway status. It has been estimated that in a third of CSEC cases, traffickers approached children who ran away within the first forty-eight hours. Speckman remarks that “traffickers are highly motivated by profits and foster children are an easily renewable resource that is in high demand” (p. 415); although it must be noted that not all CSEC are recruited by pimps.77 Many
In 2012, Florida responded to the growing awareness of CSE by passing the Florida Safe Harbor Act. This law allows minors identified as victims of CSE to be deemed as dependent instead of delinquent and requires law enforcement to deliver a minor taken into custody to the Department of Children and Families (DCF). The children should be provided placement in a short term safe house, if available. Furthermore, Florida State law does not include the criminalization of minors under 18 for prostitution offenses. These laws seek to prevent sexually exploited youth from entering the juvenile justice system by providing diversion to rehabilitative services. Overall, Florida legislation on CSEC has been well received by human trafficking advocates; for example, in 2017, Shared Hope International’s Protected Innocence Challenge report card gave Florida an “A” for the quality of its CSEC laws.

Having good protections is particularly important in Florida as it represents the third highest call volume to the National Human Trafficking Resource Center Hotline. Between 2013 and 2015 there were 1,136 reports, with 367 (32%) involving minor victims. Within this population, 83.6 percent were female and 16.4 percent were male. The Florida Department of Children and Families creates a daily report used to identify a potential CSEC victim in out-of-home care. On February 23, 2016, 814 children met the criteria as a potential CSEC, from that risk pool, 214 children were verified as sexually exploited. Reid et al. point out that the low number of verified reports often reflects the level of proof available to DCF investigators. With approximately 70 percent of trafficking cases involving unknown non-caregivers and youth uncooperative with the investigation, gathering sufficient proof to verify a report is difficult. Unfortunately, the result is that many trafficked youth remain with their perpetrators and do not receive services.

The result of being trafficked can be devastating to an adolescent’s mental and physical health and have lifelong repercussions. Landers et al. note that child welfare systems are responding to reports that between 50 to 80 percent of sexually exploited children have histories with child welfare, but developing effective programs requires an understanding of the population being served. To date, research on CSEC is limited and generally not empirically based. The authors sought to address the gap in the literature by developing a comprehensive demographic and clinical profile of sexually exploited children living in Miami, Florida. The 87 youth in the study were participants in CHANCE, a specialized treatment program for CSEC in Florida’s child welfare system. Although the youth demonstrated a variety of experience and need, a profile did emerge. The findings indicated that the youth experienced high rates of abuse prior to exploitation (e.g., 86% had a history of sexual abuse) and the majority were survivors of complex trauma based in histories of multiple forms and repeated episodes of abuse. Half of the youth did not see themselves as exploited and 68 percent showed evidence of “trauma bonding” with the perpetrators. The majority of youth had moderate to severe needs related to family of origin functioning, educational functioning, and emotional and behavioral functioning. The greatest challenges for the youth were oppositional and defiant disorders that caused emotional harm to others (46 percent), anxiety that significantly affected the ability to function (51%), and depression that significantly affected the ability to function (62%). Approximately 47 percent of youth had evidence of substance abuse that interfered with life functioning. The most common risky behavior was running away. Within the 30 days prior to program entry, 84 percent of youth had a runaway episode. The authors highlighted the unique profile of CSEC compared to other traumatized children. For example, in a child welfare study in Illinois approximately 35 percent of children had histories of complex trauma compared to the 98 percent of youth at CHANCE. Trauma experiences clearly play a role in the lives of sexually exploited children, both predisposing them to victimization and consequent to victimization.

A study of post-trafficked girls and women in Europe found that the majority of victims experienced clinically significant levels of anxiety, depression, and PTSD. The rate of mental disorders increased for those who experienced injuries and sexual violence while trafficked and spent over six months as victims. There was frequent comorbidity between PTSD, depression, and anxiety among trafficked girls and women. More time since trafficking was associated with lower levels of depression and anxiety but not of PTSD. The physical health of victims is also affected. They often experience high rates of violence-related injuries, reproductive health needs, sexually transmitted infections, and unplanned pregnancies. Furthermore, the high rates of injection drug use and unsafe sex among victims leaves them vulnerable to infections such as HIV and hepatitis C. Chronic conditions such as asthma, diabetes, and sickle-cell anemia are often left untreated.

Risk factors for sexual exploitation of youth differ by gender. Commercially exploited boys are overlooked by researchers and providers, even though the number of sexually exploited boys appears to be quite high. An estimate of prostituted youth in New York City, NY found that 53.5 percent were male, 42 percent were female and 4.5 percent were transgender. In a study of risk factors identified by adverse childhood experiences scores, it was found that all forms of maltreatment except for physical and emotional abuse were predictive of human trafficking for girls. For boys, only those who experienced sexual abuse and emotional abuse were significantly at risk for CSE. The odds for exploitation were 2.55 times greater for boys experiencing emotional abuse and 8.21 times greater for boys reporting sexual abuse. However, for both boys and girls, sexual abuse was the strongest predictor for human trafficking. Another study that focused on gender differences in commercial sexual exploitation pathways found that younger age at first sexual experience was significantly related to commercial sexual exploitation for boys, but this risk factor was not linked to commercial sexual exploitation for girls. The findings also suggested that girls’ vulnerability to commercial sexual exploitation was more likely to be linked to earlier use of alcohol or drugs, but no such link was found for boys. More study is needed to understand the risks factors associated with child sexual exploitation, especially for boys.

LGBTQ youth are at higher risk for sexual exploitation due, in part, to their marginalized place in society and higher incidences of homelessness. Research has found that LGBTQ youth are overrepresented in the foster care system. Approximately 4-6 percent of youth nationally identify as LGBTQ. Whereas, a recent study by Mitchell, Panzarella, Gryniewicz, and Galuppo...
found that 15.5 percent of their sample of former foster youth identified as LGBTQ, and a Los Angeles County study reported that 19 percent of youth in out-of-home care identified as LGBTQ. More specifically, 5.6 percent of the foster youth identified as transgender compared to 2.25 percent in the general youth population. LGBTQ foster youth are also at increased risk for running away. In one study, 78 percent of youth were removed or ran away from placement because of hostility to their LGBTQ status. Many of these youth find themselves living on the streets and further victimized. The U.S. National Coalition for the Homeless estimates that 20 percent of the homeless youth population is comprised of LGBTQ youth. Of this 20 percent, 58.7 percent will be exploited through sex trafficking compared to 33.4 percent of heterosexual homeless youth. Data and empirical studies are needed to identify how many LGBTQ foster youth are victims of sex trafficking. The paucity of data reflects the general “invisibility” of this vulnerable population within the child welfare system. As Wilson, Cooper, Kastanis, and Nezhad state, the “…overall lack of systematic data collection on LGBTQ youth in foster care limits the ability of the child welfare system to address the unique challenges of this group” (p. 5).

The Florida child welfare system has embraced the paradigm shift represented by Safe Harbor legislation that views children engaged in prostitution as victims and not delinquents. Nevertheless, providing adequate protection and support to CSEC is an ongoing challenge. Barnert et al. examined the implementation of Safe Harbor legislation in a qualitative study comprised of 37 participants from 10 states, including Florida. The interviewees were all experts in the field of child welfare and/or sexually exploited youth. The findings revealed several compelling challenges in the implementation of Safe Harbor laws. There was consensus that states lacked sufficient safe harbor placements and specialized services designed for sexually exploited youth.

An unintended consequence of this was that “police officers, judges, and prosecutors were bypassing the law by detaining commercially sexually exploited youth for charges other than prostitution when it was perceived that alternate services and placements were lacking. Thus, when diversion programs were insufficient, bypassing the law served as a ‘safety valve’ that compensated for inadequate Safe Harbor programs” (p. 258). Participants all cited insufficient funding as the primary barrier to placement and services. Although Florida has established a fund for CSEC consisting of fines levied on sex offenses, very little of the funding is reaching service providers.

More assistance is needed from the state to identify alternative funding sources to support the legislative intent of diversion placement options and services. Without additional support, some experts expressed concern of “system dumping” of CSEC where neither justice nor child welfare will accept primary responsibility for the youth. Finally, the experts agreed that evidence-based prevention programs are essential to the fight against child sexual exploitation but funding is lacking for both the development and evaluation of prevention programs. The authors of another qualitative study with state child welfare experts concluded that

… despite the political and social interest in CSEC and a focus on innovative and progressive responses to victims of CSEC, much remains unknown about both sexually exploited youth and the effectiveness of Safe Harbor laws. For example, researchers have not yet examined the effects of repeated contact with the criminal justice system on sexually exploited youth. Additionally, no studies to date have systematically evaluated Safe Harbor policies in states. Consequently, important questions remain. For example, do (some) Safe Harbor laws reduce youth reconnection with the criminal or juvenile justice systems? Do these laws increase youth contact and benefit from social and mental health services? Are they associated with reduced risk of youth revictimization? Answers to these and other questions could and should help drive the development of more effective Safe Harbor policies (p. 6).

To date, there are few studies looking at the pathways to successful exit from the “life.” Yet, however difficult, youth do permanently escape. A qualitative study of former victims of commercial sexual exploitation explored their route to independence. All of the participants exited commercial sexual exploitation by the age of 17. The open-ended interviews with 13 predominantly women of color age 21 to 26 revealed that all of the participants reported wanting to be free from psychological and physical abuse; 8 of the participants stated pending motherhood was their prime motivator for leaving; and 12 of the participants mentioned family’s tangible and/or emotional support as the motivator of their successful exit. The study’s author noted that “there have not been any evidence-based practices identified that indicate efficacy in effectively helping minors successfully exit commercial sexual exploitation” (p. 92). However, the study results indicate that along with fostering positive family connections, an effective intervention should include the clinician or case manager listening to the voices of survivors, respecting them as subject matter experts, being non-judgmental, providing encouragement, and not leaving when they resist.

Lesbian, Gay, Bisexual, Transgender, and Questioning Youth (LGBTQ)

According to a Gallup Poll, 3.5 percent of adult Floridians identify as LGBTQ, while approximately 4-6 percent of youth nationally identify as LGBTQ. The rate of LGBTQ youth in the child welfare system is somewhat higher, ranging from 4 – 10 percent. However, a recent study by Mitchell, Panzarello, Grynkiewicz, and Galupo (2015) found that 15.5 percent of their sample of former foster youth identified as LGBTQ. Whereas, a Los Angeles County study reported that 19 percent of youth in out-of-home care identified as LGBTQ. Crossover youth are even more likely to identify as LGBTQ. A survey of youth in detention who had previous or concurrent child welfare involvement found 20 percent to identify as LGBTQ; although there was a gender difference with 14 percent of boys identifying as GBQ or gender nonconforming and 40 percent of girls identifying as LBQ or gender nonconforming. Adolescents in the child welfare system who are LGBTQ face many challenges in their families of origin and in the foster care system.
Challenges

• Rejection and/or conflict with their families of origin
• Higher rates of physical and sexual abuse in their families of origin than gender conforming straight youth with child welfare involvement
• Higher rates of depression, anxiety, trauma-related beliefs such as self-blame/stigmatization, suicidal ideation and attempts, and substance abuse than gender conforming straight youth with child welfare involvement
• More frequent placement disruptions than gender conforming straight youth with child welfare involvement
• Experiences of physical and sexual bullying, especially in group homes and residential facilities
• Insensitive, culturally incompetent care in foster care placements
• Insensitive, culturally incompetent service providers, including child welfare providers
• Higher rates of runaway events and subsequent homelessness

System Response has often failed LGBTQ youth due to a lack of culturally sensitive care. Some of the issues identified include:

• Providing insensitive or punitive response to a child’s disclosure of LGBTQ identity
• Segregating youth often with the aim of protecting the youth from bullying peer behavior but experienced as punitive by the child
• Placing the youth in more restrictive environments such as group homes because of failed foster care placements
• Failing to provide trauma-based services
• Failing to provide access to culturally-relevant community-based LGBTQ programs and activities
• Pressuring the child to comply with gender conforming behaviors

Best Practices:

• Provide trauma-informed care to address youth mental health and substance abuse.
• Create a LGBTQ open and affirming culture through culturally sensitive training for foster parents, child welfare workers, and service providers.
• Display hate-free zone posters that address tolerance for diversity and embrace the LGBTQ youth.
• Have strict rules against bullying and abuse of peers based on sexual orientation.
• Avoid segregating youth, whenever possible, due to their sexual identification.
• Provide safety for transgender youth by allowing them to identify with their gender of choice while offering precautions such as separate showering facilities or times and private rooms.
• Network with the LGBTQ community to recruit potential foster parents.
• Create LGBTQ resource guides for caregivers and youth that identify age-appropriate recreational activities and programs in their communities.
• Revise policies and procedures to reflect the value of diversity within the agency and anti-harassment based on sexual orientation.
• Develop grievance procedures for LGBTQ youth and hire an ombudsman to review all grievances.
• Provide evidence-based programming for LGBTQ youth, such as the recruitment of mentors from the LGBTQ community or agencies such as the Zebra Coalition in Orlando.

Summary

In summary, the children brought into care have a myriad of emotional, behavioral, and developmental challenges. Yet, they also possess strengths, unique abilities, and resiliency. This report will assist the workgroup in determining the services needed to maximize each child’s potential.
References


78 Florida Safe Harbor Act, § 39.001(4) (2012)


