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Behavioral health needs and service use among those who've aged-out of foster care

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ABSTRACT

This paper is the first study to use a multi-state sample to longitudinally explore the relationship between remaining in foster care beyond age 18, behavioral health needs, and receipt of behavioral healthcare services. The study began with a sample of 732 older youth in foster care and followed them longitudinally for six years, after all had aged-out of care. Indicators of behavioral health and receipt of behavioral healthcare services were measured, as well as whether or not remaining in foster care after one's 18th birthday made a difference in receiving behavioral healthcare services. We found a high need for behavioral healthcare services in the years following their 18th birthdays and a significant drop-off in service use after exiting foster care. We also found a strong relationship between remaining in care after one's 18th birthday and receipt of behavioral healthcare services among those in need. Policy implications discussed highlight the possible role of Medicaid on young adults who have aged-out of foster care with behavioral healthcare service needs, and the potential impact of the Patient Protection and Affordable Care Act. Among the treatment implications are the need for highly effective behavioral healthcare services for older youths in foster care and the need for receipt of ongoing services upon exiting foster care.

1. Introduction

Most young people transition to adulthood gradually (Furstenberg, Rumbaut, & Settersten, 2005). Well into their 20s, young adults typically rely on the social capital drawn from their families and communities for various types of assistance (Schoeni & Ross, 2005). For those who age-out of foster care, this is often not the case; many navigate the early adult years without the benefit of older adults or communities that have demonstrated tangible investments in them (Samuels & Pryce, 2008). By their 18th birthdays, youths who have aged-out of foster care typically have moved numerous times, lived in a variety of placement types (e.g., group homes, foster homes, kinship care), and changed schools repeatedly (Havlicek, 2010; Pecora et al., 2003). Given this, it is unsurprising that they tend to struggle in a variety of life domains in their early adult years. For example, when compared to a nationally representative sample of same-age peers at age 26, they are far less likely to be in stable housing, earning a living wage, and to have remained out of jail (Courtney et al., 2011).

One possible explanation for the notable struggles among those who age-out of foster care is that they have high levels of behavioral health needs, as behavioral health needs are correlated with a variety of overlapping negative outcomes in adulthood (e.g. Chartier, Walker, & Naimark, 2009; Folsom et al., 2005; Sampson & Laub, 1995). Youths in foster care are high consumers of behavioral healthcare services (McMillen et al., 2004; Shin, 2005), yet service use drops precipitously upon exit from care for reasons that are unclear (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; McMillen & Raghavan, 2009).

Exploring differing state policies with regard to behavioral healthcare service-access could help explain differences in behavioral healthcare needs and receipt of services among youths aging-out of foster care. This is the first study to use a multi-state sample to longitudinally explore the relationship between remaining in care beyond age 18, behavioral health needs, and receipt of services.

2. Background

Entering foster care has been robustly associated with an increased risk for a variety of behavioral health needs (Pecora, White, Jackson, & Wiggins, 2009). Is the counterfactual for this that behavioral health needs decrease when youths later exit? According to two recent studies of older youths in foster care, perhaps, although the timing of their exits might matter: Munson and McMillen (2010) found higher depression scores among 19 year olds who had exited foster care compared to those who remained. Similarly, Narendorf and McMillen (2010) found that exiting foster care at 18 years old predicted a spike in substance use, while exiting at 19 years old did not.

From these findings, one might conclude that continuing foster care after one's 18th birthday serves a protective role against some behavioral health needs. However, it is also possible that trends in behavioral health needs may differ by type of problem, regardless of foster care

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status in youth. For example, substance abuse may abate among many in early adulthood as a function of maturity (Chen & Kandel, 1995; Chen & Jacobson, 2012), regardless of the timing of one's exit from foster care, whereas depression and post-traumatic stress disorder (PTSD) symptomology might be more enduring in adulthood (Fergusson, Horwood, Ridder, & Beautrais, 2005; Olino, Klein, Lewinsohn, Rohde, & Seeley, 2010). To better understand the possible long-term benefit that remaining in foster care has on behavioral health needs among those who age-out of the foster care system, it is necessary to track youths who have exited foster care at different ages after reaching the age of majority and to follow them into adulthood.

2.1. Behavioral healthcare service receipt

Older youths in foster care consume more behavioral healthcare services than same-age peers not in foster care (Farmer, Burns, Chapman, Phillips, Angold, & Costello, 2001; Leslie et al., 2005; Shin, 2005), including Medicaid recipients (Rosenbach, Lewis, & Quinn, 2000), and others involved in the child welfare system but remaining at home (Burns et al., 2004; Harman, Childs, & Kelleher, 2000). However, the relationship between behavioral health needs and the use of behavioral healthcare services among older foster care youths is unclear, as findings have been mixed (McMillen et al., 2004; Shin, 2005), and approximately half of all older youths in foster care receive behavioral healthcare services within the 12 months prior to exiting care (Courtney et al., 2001; McMillen et al., 2004). Furthermore, regardless of behavioral health needs, remaining in foster care after turning 18 has been found to be the single greatest predictor of behavioral healthcare service use among older foster care youths (McMillen & Raghavan, 2009).

The behavioral healthcare service-use picture changes dramatically for older youths in foster care upon exiting, reducing by more than 50% in the year following exit from foster care (Courtney et al., 2001). However, the relationship between this drop in service use and behavioral health needs is unclear. Courtney and Dworsky (2006) found, at age 19, youths in foster care with behavioral health needs were twice as likely to have received services compared to same-age youths with similar needs who exited care. Are young people remaining in foster care after their 18th birthdays receiving services because they are in greater need than those who exit? Or, are those who exit equally in need of services as those who remain, but less able to access them for reasons that are not yet understood?

2.2. State policy and service receipt

Traditionally, Medicaid eligibility for youths in foster care was dropped upon exiting foster care and only re-accessed among those with a qualifying reason in adulthood (e.g., income-qualifying pregnancy or parenthood, disability). It is possible that the high consumption of behavioral healthcare services among all foster care youths while in care (Cosgrove, Frost, Chown, & Anam, 2013; Jaudes et al., 2012) has contributed to most states extending Medicaid eligibility to former foster care youths until their 21st birthdays under the Foster Care Independence Act (Chafee Act). However, it is unclear how the Chafee Act has affected behavioral healthcare service use, as many already qualified for Medicaid after exiting foster care for a variety of reasons, including behavioral health disabilities, and did not enroll, or enrolled but did not seek services (Collins, 2004). Others enrolled, or were automatically enrolled, but did not access services because they were unclear about how to do so (Pergamit, McDaniel, Chen, Howell, & Hawkins, 2012). Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) superseded the Chafee Act by extending automatic Medicaid qualification to all youths aging-out of foster care until their 26th birthdays. It remains unclear what effect this will have on behavioral healthcare service use.

3. Research questions

The purpose of this study is to explore the prevalence of behavioral healthcare needs and the continuity of behavioral healthcare services among youths aging-out of foster care, including the relationship between remaining in foster care after one's 18th birthday and the receipt of services. Specifically, we ask the following four questions:

In the years following a transition from foster care to adulthood:

1) Do indicators of behavioral health change?
2) Does behavioral healthcare service use change?
3) Does the relationship between services needed and services received change?
4) Are state-level policies associated with the mandatory age of foster care exit related to the receipt of behavioral healthcare services among those in need of services?

4. Research design & methods: the Midwest Study

Data for these analyses were taken from four waves of the Midwest Evaluation of the Adult Functioning of Former Foster Youth ('The Midwest Study'), a longitudinal survey of youths in the states of Illinois, Iowa, and Wisconsin, who were in out-of-home care for at least one year immediately prior to discharge. The youths exited foster care between their 17th and 22nd birthdays and followed until they were 23 or 24 years old. The original study's purpose was to determine how well these youths transitioned to adulthood (Courtney & Dworsky, 2006). Exclusion criteria for the study included having a developmental disability, in-patient status at a psychiatric institution, and incarceration, as these were thought to interfere with the transition to adulthood.

In the original study, a systematic sampling procedure was used to obtain a representative sample (Henry, 1990). The sampling frame consisted of active cases identified by the states' public child welfare agencies between April and June of 2002. All eligible youths were selected in Iowa and Wisconsin, and a random selection of 67% of eligible youths was selected from Illinois, which had a much larger out-of-home care population than either of the other two states. Of the 880 youths selected for recruitment, 110 were determined to be ineligible and excluded for the following reasons: physically or mentally incapable ($n = 33$); incarcerated or resident of a locked psychiatric facility ($n = 40$); runaway or missing from assigned home ($n = 16$); out-of-state when data collection began ($n = 13$); adopted at the time of data collection ($n = 8$). Of the remaining 770 cases, 732 consented to participate and completed an in-person baseline interview (95% response rate at baseline). At baseline, 51.6% of participants were female. Fifty seven percent reported to be African American, 30.9% Caucasian, and 12.2% reported differently on race. Six hundred and three completed Wave 2 (82% response rate), 591 completed Wave 3 (81% response rate) and 602 completed Wave 4 (82% response rate). There were no racial differences between those who responded at subsequent waves and those who did not. There were slightly more female respondents at Wave 2 (54.1% female, $x^2 = 8.048$, $df = 1$, $p = .003$) and Wave 4 (53.5% female, $x^2 = 8.048$, $df = 1$, $p = .003$).

In Iowa and Wisconsin, foster care terminated upon the respondents' 18th birthdays. In Illinois, young people were permitted to remain in foster care until age 21 and most chose to do so. Seventy two percent of Illinois participants were still in care at age 19. At Wave 3, none of the participants were still in care.

4.1. Procedure

In the original study, all recruitment and data collection followed IRB-approved protocols. Foster care providers of the prospective participants were informed of the study through a letter and verbal communication with the youths' caseworkers. Youths were sent letters regarding the study and gave informed consent when contacted for in-person