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Executive Summary

In Florida’s child welfare system, most children and youth are covered under the Child Welfare Prepaid Mental Health Plan (CW-PMHP) for their mental health service needs. The Community-Based Care Partnership, LTD (CBC Partnership) contracts with the Agency for Health Care Administration to administer the CW-PMHP. The CBC Partnership is comprised of Magellan Behavioral Health of Florida (the managed care organization) and Community-Based Care of Central Florida (a CBC lead agency) as general partners and additional CBC lead agencies as limited partners.

This study examined the needs and experiences of youth served under the CW-PMHP who are aging out of the foster care system and transitioning to adulthood by gaining the perspective of foster parents who care for them and the CW-PMHP service providers for this age group.

Specifically, the provider survey component asked respondents to share information concerning the challenges and unmet needs faced by youth aging out of care, strategies used to address these needs, availability of resources, and their experience and needs as providers. The majority of the provider respondents reported having five years of experience or more working with youth aging out of foster care, with just under half having ten years of experience or more. Furthermore, most of the providers had received training focused on serving this population. Additional training needs were noted in the areas of available community resources and services, content of life skills/independent living classes to better understand how to complement education received by youth with mental health services, and the process used by the child welfare system to prepare youth for aging out of foster care.

Not surprisingly, CW-PMHP providers indicated that youth who are aging out of foster care face multiple and overlapping challenges most significantly related to finding employment, meeting their educational and mental health needs, and securing housing and financial resources. Substance abuse was also noted as a challenge by the majority of providers. In addition, providers reported that youth have unmet service needs including mental health counseling before and after aging out, more effective behavioral interventions, and services to address trauma and loss. Providers also expressed concern for a lack of availability and effectiveness of services and resources for youth preparing to age out of foster care. Barriers such as transportation, the geographic location of services, wait lists, health insurance, and discontinuity of care were indicated.

Related to treatment strategies, providers reported utilizing various evidenced-based and best practices to address the needs of youth they serve. These included incorporating independent and life skills training, Cognitive Behavioral Therapy, family team conferencing, and youth-focused community service connections into their service and treatment plans. The use of client-centered practice, Dialectical Behavior Therapy, trauma-focused therapy, and solution-focused therapy were also noted. Providers emphasized the importance of collaboration and using a multi-disciplinary, team-based approach specifically by coordinating with independent living staff, connecting with community supports, and involving the youth and family members in the treatment planning process. Making referrals to targeted case management and independent living coordinators, providing information about adult resources and services, and assisting the youth to schedule intake appointments were reported by CW-PMHP providers as strategies used to connect youth to adult resources prior to aging out of the system. Survey respondents suggested that youth would benefit from greater availability of mentorship,
advocacy, and support that continue after they age out of foster care and independent living programs that would begin to work with youth at a younger age.

Interviews with foster parents who care for older teens expected to age out of foster care were conducted to better understand the types and helpfulness of mental health and independent living services received, the availability of adult supports, youth plans for the future, and successes and challenges youth are facing.

Overall, foster parents indicated mental health and independent living services were available to youth preparing to transition out of foster care. Furthermore, the majority of foster parents reported that mental health services were helpful at meeting youth needs. However, foster parents suggested that mental health services could be more beneficial if youth preparing to transition out of foster care had more control over participating in services or not. It was also noted that youth need more help to manage feelings of anger and decrease aggressive behaviors.

Concerning services and supports to help youth transition to adulthood, foster parents reported independent living specialists, child welfare and targeted case managers, school counselors, tutors, and Guardians ad Litem to be beneficial components of the youth’s support system. Despite these positive elements, foster parents stated that youth typically do not have a strong network of support once they age out of foster care. Foster parents often serve as the primary means of support and guidance during and after the youth’s time in care. In addition to modeling how to manage adult responsibilities through typical day-to-day interactions, foster parents reported assisting youth in preparing for adulthood by helping them to get a driver’s license, obtain a job, apply for continued education, and find affordable housing. Foster parents suggested making the independent living classes more applicable to the individualized needs of youth and to include more hands-on and frequent contact.

Foster parents described significant ongoing needs of youth aging out of foster care, including overcoming the impact of abuse and familial loss and managing feelings of depression and anger. Academic delays were reported to be one of the most persistent challenges experienced by youth currently and formerly cared for by the foster parent respondents. Learning disabilities, developmental disorders, interference of behavioral and emotional symptoms, and lack of adequate resources were stated as factors that impede academic success. Furthermore, foster parents expressed serious concern about the long-term impact that educational failures can have on a young adult’s future.

In addition to greater educational support for youth, suggestions were made as to how the system could offer more help to foster parents. These included encouraging foster parents to have more involvement in the mental health treatment and independent living services received by youth and to become more engaged with the available foster parent support meetings and resources. Foster parents stated that they would also like additional training on caring for the individualized mental health and medication needs of youth and how to help teenagers deal with their anger. Similarly, it was noted that child welfare case workers could benefit from more training on working with teens with mental health issues who are approaching adulthood.

Policy Recommendations

Based on the study findings outlined above, the following policy recommendations are offered to AHCA and the CBC Partnership for consideration in future planning:

- The CBC Partnership should, in collaboration with community providers, consider
creating and maintaining an internet-based list of available services and resources within each county in Florida related to youth aging out of foster care and transitioning to adulthood. This list should include eligibility requirements for services to facilitate the treatment planning process.

- The CBC Partnership, child welfare agencies, and mental health service providers should consider developing and updating online training modules related to serving the specific needs of youth with mental health needs who are aging out of foster care and transitioning to adulthood with different tracks for providers and youth. Provider tracks could include such topics as available services, evidence-based or best practices, content of services offered, and techniques to motivate youth to participate in services. Youth tracks could offer the availability of services, methods of accessing services, and successful problem-solving techniques and coping skills to use when faced with barriers.

- Hands-on and real-life skills training and independent living skills training should be introduced at an earlier age to these vulnerable youth. This could increase the opportunities for successful transition due to increased exposure to and practice of these necessary skills. Also, by beginning this area of transition earlier, these youth could possibly be placed on the waiting list for specific adult services in time to have the services available when they transition, thus reducing the amount of time without services.

- AHCA and the CBC Partnership should investigate how they could better ensure youth have appropriate housing and transportation when they transition out of foster care. Improving these two areas could greatly reduce stress and increase the likelihood of the youth staying connected and receiving services necessary for their stability and ultimate success as an adult.

- ACHA and the CBC Partnership should consider continuing care in the form of follow-up with the youth after they transition to adult services. This extended time could provide necessary support and guidance in navigating housing, transportation, education, employment, health, and behavioral health issues and services, ultimately increasing the overall lifetime success for these youth.

- The CBC Partnership and mental health service providers should collaborate with child welfare agencies, foster parents, and educational providers to develop integrated intervention plans specifically targeted toward supporting the individualized educational needs and goals of youth and addressing barriers to achieving these goals.

- The CBC Partnership, in collaboration with child welfare agencies, should develop creative ways to strengthen the network of supportive adults and peers available to youth once they age out of foster care. This should include not only organizations that are specifically intended for individuals who have aged out of foster care, such as Florida Youth Shine and Connected by 25, but also entities that are not specific to foster care such as peer support and mentor groups on college campuses and those that relate to the specific career or personal interests of youth.

- The CBC Partnership, mental health service providers, and child welfare agencies should work together to ensure that interdisciplinary training and support specific to
working with teenagers with mental health needs is available and easily accessible in all service areas to foster parents, child welfare case managers, independent living specialists, and all other child welfare staff in order to serve these youth in a more collaborative and coordinated manner.

- The CBC Partnership should partner with AHCA and the adult mental health service system to ensure that adequate transition plans and agreements are in place so that no young adult aging out of foster care experiences a significant lapse in or denial of mental health services including medication management.

**Background**

In 1986, the federal government enacted the Title IV-E Independent Living Program to assist young people transitioning out of the child welfare system to live on their own. In 1999, the Foster Care Independence Act and its amendments created the John Chafee Foster Care Independence Program, which expanded eligibility for services. It broadened funding for additional services such as housing and food, in addition to vouchers for postsecondary education and training. It also allowed states to extend Medicaid coverage to former foster youth until age 21. In 2008, the Fostering Connections to Success and Increasing Adoptions Act amended Title IV-E to extend the age of Title IV-E eligibility from 18 to 21. Starting in federal fiscal year (FFY) 2011, states may claim federal reimbursement for the costs of foster care maintenance payments made on behalf of Title IV-E eligible foster youth until they are 21 years old. This has great significance for both the states who provide care and for youth who are transitioning out of foster care.

**Youth Aging Out of Foster Care**

Nationwide, it is estimated that over 60,000 youth ages 16 and 17 (15% of total children in care) were in foster care in 2011 and over 26,000 (11% of total children exiting care) aged out of foster care in the same year (United States Department of Health and Human Services [USDHHS], 2012a). Similarly, in Florida, 2,600 youth (13% of total children in care) were ages 16 and 17 and 9% of total children exiting care (1,347) aged out of foster care in 2010 (USDHHS, n.d.). While the number of children living in foster care has continued to decrease since FFY 2002 (USDHHS, 2012b), the number of youth aging out of foster care has only begun to decrease over the past several years (McCoy-Roth, DeVoght, & Fletcher, 2011). Furthermore, of all children exiting foster care, the proportion of youth aging out steadily increased until remaining constant in recent years (McCoy-Roth et al., 2011; USDHHS, 2012a).

**Poor Outcomes Follow Youth Who Age Out of Foster Care**

Numerous studies have documented the serious challenges facing many youth who age out of foster care. One in four of these youth will be incarcerated within the first two years of leaving foster care (Culhane et al., 2011; Freundlich, 2007; Reilly, 2003) and one in five will become homeless (Sermons & Witte, 2011). In Florida, 10% to 14% of youth who aged out of the foster care system reported they had spent at least one night homeless since leaving care from 2008 through 2010 (Florida Department of Children and Families, 2010). Barely half of these youth will graduate from high school (Emerson, 2006; Pecora et al., 2003; Wolanin, 2005), and less than 3% will receive college degrees (Brandford & English, 2004;
Courtney et al., 2007; Davis, 2006; Wolanin, 2005). Because youth who age out of foster care also experience disproportionate rates of unemployment or underemployment (Macomber et al., 2008; Pecora et al., 2005), they are more likely to lack health insurance for essential health services (Christian & Schwarz, 2011; Fox, Limb, & McManus, 2007; McMillen & Raghavan, 2009; Raghavan, Shi, Aarons, Roesch, & McMillen, 2009). It is estimated that one in every two children in foster care has chronic medical problems unrelated to behavioral concerns (Rubin, Halfon, Raghavan, & Rosenbaum, 2005) and that these chronic conditions increase the likelihood of serious emotional problems (Rubin et al., 2004).

**Prevalence of Mental Health Issues**

In addition to physical and chronic somatic disorders from child maltreatment and neglect (McMillen et al., 2004, 2005; Shin, 2006), children in foster care are more likely than other children who receive Medicaid to have a mental health or substance abuse condition (Rosenbach, 2001). Further, the prevalence of mental health conditions and the use of medications increase with age (McMillen et al., 2005). In their review of the literature, Christian and Schwarz (2011) identified strong associations between cumulative traumatic childhood events and adult physical and mental health disease, as well as higher levels of health care utilization in adulthood. By the time youth transition out of foster care, the rates of major depression and posttraumatic stress disorder are two to three times greater than in the general population of youth (McMillen et al., 2005; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Over half of the youth who had transitioned out of foster care were diagnosed with one or more disorders, a quarter of foster care youth who aged out had post-traumatic stress disorder (PTSD), over 20% had major depression, and over 17% had social phobias (Pecora et al., 2005). Alcohol and substance abuse were also prevalent during foster care (Courtney, Terao, & Bost, 2004) and increased steeply in the year the youth left foster care (Narendorf & McMillen, 2010).

**Barriers to Transitioning Out of Care**

Generally, youth transitioning out of foster care have poorer education outcomes; limited financial resources; few, if any connections to personal, family, or network supports; and limited support from the child welfare system. They leave a health care system to which they are accustomed and move into adult service systems. However, there are numerous barriers to moving across service systems, such as fragmentation or discontinuation of care (McMillen & Raghavan, 2009; Osgood, 2005; Osgood, Foster, & Courtney, 2010; Ringeisen, Casanueva, Urato, & Stambaugh, 2009), medical, child welfare, and social issues (Christian & Schwarz, 2011), and difficulties in navigating both developmental and institutional transitions (Vander Stoep, Davis, & Collins, 2000). Munson and colleagues (2011) found that only 22% of youth received continuous mental health care during the transition from foster care, with 78% experiencing interruptions or discontinuation of care. They suggested that youth are overwhelmed with trying to navigate the complexity of adult service systems on their own and that strategies, such as medical homes, may assist in their transition to adult services systems (Munson et al., 2011).

Christian and Schwarz (2011) viewed the three most significant barriers to youth transitioning out of foster care as lack of shared planning among pediatric and adult systems, loss of case management (specifically child welfare), and loss of insurance coverage. An additional barrier is the lack of an Early Periodic Screening, Diagnostic, and Treatment (EPSDT)—related mandate for Medicaid-eligible young adults. Nationally, eligibility criteria for mental
health services are more stringent in the adult mental health system than in the pediatric system, making it more difficult for youth to continue services during this transitional phase (Christian & Schwarz, 2011).

**Improving Transition Support Services**

Davis, Geller, and Hunt (2006) determined that transition support services in the United States are inadequate to successfully address the needs of youth transitioning to adult systems of care. They ask several questions addressing service capacity such as: How much transition service capacity is sufficient? and What types of services offered and by which systems are sufficient? Related questions included: What services are effective? and What factors influence accessibility and engagement in those services? From their observations, Davis and colleagues concluded that the fragmentation (including funding and eligibility) of child and adult mental health systems is so severe that explicit bridges will need to be created to overcome fragmentation.

A number of longitudinal studies on youth who have transitioned from foster care provide insights as to what services and supports are necessary to increase the probability of positive outcomes. Pecora et al. (2003, 2005) suggest that a constellation of characteristics predicts the level of success transitional youth may achieve. Looking at a composite of educational attainment, income, mental and physical health, and relationship satisfaction, the following supportive elements were identified: life skills preparation, minimized academic problems, completing a high school diploma or GED before leaving foster care, scholarships for college or job training, minimized use of alcohol or drugs, and not being homeless within a year of leaving foster care. Life skills development approaches and independent living skills include handling finances, managing households, and navigating post secondary education admission and financial aid processes (Courtney et al., 2004; Davis, 2006; Dworsky & Pérez, 2009; Pecora et al., 2003, 2005; Wolanin, 2005). However, life skills and independent living programs must also ensure that the relevance and quality of counseling services are available to meet the needs of youth who are transitioning out of foster care (Arnai & Krebill-Prather, 2008; Brandford & English, 2004; Christian & Schwarz, 2011; Clark & Davis, 2000; Courtney et al., 2007; Courtney, Dworsky, Lee, & Raap, 2010).

**The Current Study**

Most children in Florida's child welfare system and residing in foster care are covered under the Child Welfare Prepaid Mental Health Plan (CW-PMHP, the Plan) for their mental health needs. The Community-Based Care Partnership, LTD (CBC Partnership) contracts with the Agency for Health Care Administration to administer the CW-PMHP. The CBC Partnership is comprised of Magellan Behavioral Health of Florida (the managed care organization) and Community-Based Care of Central Florida (a CBC lead agency) as general partners and additional CBC lead agencies as limited partners. Given the myriad challenges for youth with mental health issues who are approaching adulthood and aging out of foster care, it is important to conduct an assessment beyond their mental health needs to gain greater insight into how they are being prepared to transition from a youth-based system to establishing and sustaining an independent and healthy lifestyle in the adult system.

This study examined the needs and experiences of youth served under the CW-PMHP who
are aging out of the system and transitioning to adulthood. The evaluation questions guiding this study were:
• What are the needs and experiences of youth aging out of the CW-PMHP specifically related to transitioning to adulthood according to young adults, foster parents, and providers?
• What are the strategies that providers are utilizing to address the needs of youth aging out of the CW-PMHP and transitioning to adulthood?

There were two components of this study that consisted of: (a) an electronic survey sent to mental health providers serving 16-17 year old youth transitioning out of foster care and into adulthood, and (b) interviews with foster parents caring for this population of youth. The specific methodology for each component is detailed below. All study activities were conducted in accordance with approved University of South Florida Institutional Review Board procedures. This study was funded by the Agency for Health Care Administration.

Methods – Provider Survey

Sampling Procedures

Mental health providers serving 16-17 year old youth who were enrolled in the CW-PMHP were the population targeted to receive the survey. The research team received a statewide list of individual providers and provider agencies from the CBC Partnership. This list consisted of 753 provider agencies and individual providers. The list was reduced to 290 unique provider agencies and 172 individual providers when unduplicated by phone number and satellite offices.

Research team members made a maximum of three attempts to contact the provider agencies and individual providers by phone; a total of 193 were successfully contacted. Each provider contacted was informed of the evaluation in the following manner: the study was briefly explained, a letter from the study leads providing further explanation and a copy of the study proposal was offered (via e-mail), and their participation was requested. Reasons why some agencies and individuals did not participate included the following:
• The provider did not work with 16-17 year old youth.
• The provider only completed Comprehensive Behavioral Health Assessments.
• The provider did not participate in the CW-PMHP.
• The provider elected not to participate in the study at that time.
• The provider did not send the names and email addresses they had agreed to send.

The final list of names and email addresses was comprised of 545 staff from 36 agencies and 12 individual providers from every AHCA Area participating in the CW-PMHP.

Instrumentation

A provider survey was developed that consisted of 14 questions. The first three questions requested the following information about the respondent: their provider agency, their professional role/title, and the length of time they have worked with this population. The next

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1The Child Welfare Prepaid Mental Health Plan serves enrolled youth through the end of the month in which they turn 18. These youth are referred to as 16-17 year olds in this report.
two questions addressed the types of services they provide to youth enrolled in the CW-PMHP who were aging out and transitioning to adulthood, and the needs and challenges these youth face. The remaining nine questions addressed the following issues:

- Training they have had specific to youth transitioning to adulthood and what additional training would be helpful to better serve this population.
- Evidence-based practices or best practices they have used in their work with this population.
- The unmet behavioral health needs of this population served.
- The treatment planning process utilized to identify and meet the various needs for this population.
- Resources available to the youth who have aged out of the CW-PMHP, ease of access or obstacles that inhibit access, and connecting these youth to resources available in adulthood.
- Suggestions to better prepare these youth for adulthood and improve the experiences, opportunities, and support available to youth aging out of the system.
- Additional information related to the experiences and needs of these youth.

The survey was developed and distributed using the online survey management software Qualtrics. Four attempts were made to invite survey participation. After the survey was sent the first time to 545 individuals, three subsequent waves were sent 7 to 10 days apart to all those who had not yet responded. Thank you emails were sent after the survey was closed. A total of 100 individuals completed the survey, representing an 18.3% response rate. There were survey respondents from all AHCA Areas where the CW-PMHP has been implemented. There were also survey respondents from Areas 1 and 10, and Manatee and Polk Counties in Area 6 which are excluded from the CW-PMHP, but sometimes have children referred from other CW-PMHP counties.

Methods – Foster Parent Interviews

Sampling Procedures

Recruitment Flyers

The research team developed recruitment flyers which described the purpose of the study, offered $25 for participation, and provided a toll-free phone number for potential participants to contact the research team directly.

Foster Parents

To be eligible for the study, a foster parent must have parented a 16-17 year old that was expected to age out of foster care and who had received mental health services through the CW-PMHP in the past year, or a youth that had already aged out and received mental health services during their last year in foster care. The process for recruiting foster parents began with the identification of child welfare Community-Based Care (CBC) lead agencies that geographically represented all regions of the state. The following CBCs were selected: (a) Big Bend Community Based Care, Inc. (Northwest Region), (b) Family Support Services of North Florida (Northeast Region), (c) Child and Family Connections (Southeast Region) (d) Kids Central,
Inc. (Central Region), (e) Eckerd Community Alternatives (Suncoast Region), and (f) Our Kids of Miami-Dade/Monroe, Inc. (Southern Region). These CBCs were asked to identify foster parents who had at least one youth in the desired age range who had received at least one mental health service through the CW-PMHP within the past year. Foster parents were then recruited in one of two ways: (a) the research team utilized the contact information provided by the CBCs or their case management organizations and mailed recruitment flyers to foster parents and followed up with at least one telephone call or email message, or (b) the CBCs or case management organizations made the first contact with foster parents and obtained permission from them to be contacted about the study and then the research team made at least two attempts to reach them by telephone.

**Young Adults 18+ Years of Age Who Aged Out of Foster Care**

Simultaneous efforts were made to recruit young adults 18 and over who had transitioned out of foster care. To be eligible for participation, young adults had to be at least 18 years old who had aged out of foster care within the past year and received mental health services during their last year in foster care. The recruitment process utilized communication with Florida Youth SHINE, an existing statewide network of organizations that seeks to provide support to this population. Nine SHINE chapters in areas served by the CW-PMHP were invited to participate, including Tallahassee, Jacksonville, Orlando/Sanford, Vero Beach, Hillsborough County, Pinellas County, Sarasota, West Palm Beach, and Miami. Directors of each of these chapters were contacted by the Florida Youth SHINE Statewide Coordinator and were given recruitment flyers with the contact information of a USF research staff member who was available to answer any questions. Additional follow-up efforts were made by the Statewide Coordinator and a USF research staff member. Recruitment support and assistance was also solicited from the Department of Children and Families, Connected by 25, and the My Life initiative sponsored by The Partnership for Child Health. Emails soliciting assistance in recruitment were also sent to Independent Living Coordinators in geographic areas covered by the CW-PMHP. All of these efforts yielded no interviews with young adults who had aged out of foster care.

**Instrumentation**

Construction of the interview protocol was based on a review of the professional literature regarding mental health needs and service use of the population of youth being examined. A questioning route was designed that included questions about:

- the types and helpfulness of mental health services received;
- services and supports received to help the youth prepare for adulthood;
- youth plans for the future;
- the availability of adult supports when leaving foster care;
- successes and challenges the youth faced; and
- suggestions for improving the experiences of youth aging out of foster care.

Foster parents were also queried about what types of services or supports they had received as a caregiver to help the youth prepare for adult responsibilities.
Data Collection and Analysis

Semi-structured interviews were conducted by telephone and informed consent was obtained from each foster parent. Interviews were recorded with the permission of the interviewee and transcribed. Qualitative content analysis of interview data was performed by two study team members using ATLAS.ti software, with a third study team member reviewing all transcripts in order to provide impressions of general themes.

Limitations

There are several limitations that readers should keep in mind when considering the findings presented within this report. First, even though there was statewide outreach to maximize the sample size for the provider survey, the low response rate limits generalization of survey findings to the larger provider population. Second, although the purpose of qualitative research is to broaden one’s understanding of a phenomenon and not to generalize to a larger population, the small sample size for foster parent interviews must be acknowledged since there may be other experiences and opinions of foster parents caring for teenage youth aging out of foster care that are not reflected in this study’s findings. In addition, the voice of youth aging out and young adults who have already aged out of foster care was not able to be accessed by the research team and therefore is an important component that is not reflected here. These limitations partially resulted from the shortened study contract period.

Findings – Provider Survey

Surveys were sent to 545 individuals and 100 (18.3%) of these individuals returned a completed survey. Ninety-six respondents from 24 agencies and four individual/private providers participated. Thirty-one percent of survey respondents were case managers; 31% were in a therapist or counselor role (including licensed clinical social workers or licensed mental health counselors); and 15% indicated being in a managerial role. The remaining 23% noted a variety of titles including, but not limited to: psychologist, medical doctor, registered nurse, clinical specialist or support assistant, psychology resident, independent life skills coordinator, placement specialist, transition specialist, and family consultant.

Respondents’ length of time working with youth aging out of foster care and transitioning into adulthood ranged from five months to 35 years. As shown in Table 1, most providers reported having more than ten years of experience; of those respondents, over 25% reported having over 20 years of experience.

Table 1. Years of Experience Working with Youth Aging Out and Transitioning to Adulthood

<table>
<thead>
<tr>
<th># of Years</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>8</td>
</tr>
<tr>
<td>1 – 2 years</td>
<td>8</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>18</td>
</tr>
<tr>
<td>5 –10 years</td>
<td>23</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>43</td>
</tr>
</tbody>
</table>
Services Provided and Challenges

Survey respondents were asked what types of services they provide to the target population of youth. Forty-six percent indicated they only provide one type of service; 29% provide 2-3 services; and the remaining 25% provide 4 or more services. As shown in Table 2, the majority of survey respondents indicated that they provide mental health counseling (60%) and case management (50%) services. To a lesser extent, providers reported offering services focused on education, employment, housing, financial, and substance abuse treatment. Other types of services dealt with family issues, dual diagnosis, comprehensive behavioral health and bio-psychosocial assessment, treatment planning, group counseling, social skills/life skills training, linking to community agencies and services for continuity of care, support and monitoring to advocate for unmet needs, social security insurance, medication management, psychiatric evaluation, and transition to adult health care providers and specialty physicians.

Table 2. Services Provided to Youth Aging Out and Transitioning to Adulthood

<table>
<thead>
<tr>
<th>Services*</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health counseling</td>
<td>60</td>
</tr>
<tr>
<td>Case management services</td>
<td>50</td>
</tr>
<tr>
<td>Educational assistance (e.g., help enrolling in vocational program or college)</td>
<td>34</td>
</tr>
<tr>
<td>Employment referral</td>
<td>22</td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td>21</td>
</tr>
<tr>
<td>Housing referral</td>
<td>21</td>
</tr>
<tr>
<td>Assistance with finances/budgeting</td>
<td>21</td>
</tr>
<tr>
<td>Child care referral</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
</tbody>
</table>

Note: *Respondents could indicate providing more than one service type.

Survey participants were also asked what challenges and/or needs youth face as they age out of the system and transition to adulthood. Seventy-two percent of participants checked five or more of the challenges listed on the survey. As seen in Table 3 employment, education, mental health, housing, finances, and substance abuse were noted by the majority of providers as issues facing these youth. Other challenges included juvenile justice involvement, appropriate peer group and relationship development, independent living skills, accessing supportive community services, insurance/medication coverage, and transportation. One provider wrote that these youth “face every challenge [listed on the survey].”
Table 3. Challenges Facing Youth Aging Out and Transitioning to Adulthood

<table>
<thead>
<tr>
<th>Challenges*</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>88</td>
</tr>
<tr>
<td>Education</td>
<td>85</td>
</tr>
<tr>
<td>Mental health</td>
<td>80</td>
</tr>
<tr>
<td>Housing</td>
<td>78</td>
</tr>
<tr>
<td>Finances</td>
<td>76</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>66</td>
</tr>
<tr>
<td>Child care</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
</tr>
</tbody>
</table>

Note. *Respondents could indicate more than one challenge/need.

Training

Forty-nine respondents indicated they had received training focused on working with youth aging out and preparing to transition to adulthood. Providers reported receiving such training through pre-service or internship experiences, on the job trainings or experiences, and workshops or seminars. Specific training topics included independent living/life skills (31%), transition planning (9%), psychotherapy/mental health (4%), and trauma-informed care (2%).

Some respondents noted the helpfulness of the independent living and transition planning trainings. However, one respondent suggested the training was too broad and more specific training was needed. Another wrote, “There are no training programs available for specific roles of a targeted case manager aimed at that age group.”

Sixty-three respondents identified additional training needs that would benefit their work with youth aging out and transitioning to adulthood. As shown in Table 4, these included a focus on what resources and services are available in local communities (43%), the content taught in independent living/life skills so other concerned adults/professionals can work with youth to enhance this education and skill building (25%), education and vocational training options for youth (13%), any and all training topics that would improve their work with youth aging out of foster care (13%), and the process to ready youth for transition and the barriers they face once they age out (11%). One respondent wrote, “It would be helpful to have a website dedicated to this population.”
Table 4. Additional Training Needs of Providers

<table>
<thead>
<tr>
<th>Type of Training</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available community resources/services</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td>Independent living/life skills content</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Education/vocational training options</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>All training topics for youth aging out</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Transition process for youth/barriers</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Counseling/motivation/self esteem</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Mental health and case management</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Substance abuse support/relapse prevention</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parenting training</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available services for adults with disabilities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Homelessness issues/resources</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. *Respondents could indicate more than one training need.

A few respondents also noted the lack of availability of services for youth. One wrote, “Training is not the problem. It is resources available to a population that has no resources [to attend]. We can and do refer to all existing programs but if they cannot pay, they do not attend.” Two others wrote, “It would be more beneficial if there were more services to provide for our clients; rather than trainings. When there are minimal services to offer there is only so much we can do to prepare a client for the aging out process” and “It was beneficial to learn what services were available [in training sessions], but the accessibility and needed services were limited.”

Evidence-Based or Best Practices

Fifty-four respondents provided information about the evidence-based and best practices they currently use. As seen in Table 5, providers reported utilizing independent living or life skills (44%), Cognitive Behavioral Therapy (31%), family team conferencing or support teams (11%), and efforts to ensure that youth are linked to community resources (11%) to best serve youth aging out and transitioning to adulthood. Others included a focus on client-centered practice, dialectical behavior therapy, and trauma-focused and solution-focused therapy. In addition, one respondent wrote, “I bring back youth who have transitioned out of foster care to speak with youth who are still in, so they can share their experiences, and low and high points.”

One respondent emphasized the importance of encouraging youth to adopt a “refuse to lose attitude” and “that it is possible for them to reach success and it doesn’t matter what adversities they face, that they can do it.” This individual’s approach was to “help them develop the critical thinking skills required for them to make appropriate decisions, opposed to telling them what they need to do.”
Table 5. Evidence-Based and Best Practices Used by Providers

<table>
<thead>
<tr>
<th>Evidence Based/Best Practice*</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent living/life skills</td>
<td>24</td>
<td>44</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy (CBT)</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>Family team conferencing/support teams</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Ensuring youth-community service connections</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Client-centered practice</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Dialectical Behavior Therapy (DBT)/Coping Skills</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Trauma-Focused Therapy</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Solution-Focused Therapy</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Boys Town Model</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Substance abuse counseling/services</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Rational Emotive Behavior Therapy (REBT)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Exposure and Response Therapy</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>College preparation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Motivational interviewing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parenting education</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aggression Replacement Training</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sand Therapy</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Eye Movement Desensitization Reprocessing (EMDR)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. *Respondents could indicate more than one practice.

Unmet Behavioral Health Needs

Sixty-six respondents identified specific unmet needs of youth that they serve transitioning out of care. Table 6 shows that providers most often (29%) indicated that services were not meeting the mental health needs of youth, either before or after they age out. Respondents listed a number of contributing factors to unresolved mental health needs, including the complexity and persistence of the symptoms, a limited number of sessions available per year through the Plan, refusal of the youth to participate in services, and inadequate resources to ensure the youth is transported to sessions. Eighteen percent reported that youth needed better behavioral interventions that support their transition to adulthood by teaching them skills to effectively manage symptoms of depression, anger, inattention, and substance abuse. Fourteen percent reported that services were not available for youth or that the available services were ineffective. Specifically, providers stated that greater availability of services for youth and young adults with developmental disabilities; case management to assist with housing, transportation and medication management; and more affordable behavioral health
providers who accept the uninsured or underinsured are needed. Unmet needs were also noted in the areas of helping youth address past trauma or grief and loss issues, developing life skills, future planning assistance to better prepare youth for adult responsibilities, issues with mental health medication management including inconsistency in taking medications and lack of transportation to related appointments, and connecting youth with a trustworthy adult or mentor in and after their time of transition.

Table 6. Unmet Needs of Youth Aging Out and Transitioning to Adulthood

<table>
<thead>
<tr>
<th>Unmet Needs*</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health counseling/follow up</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Behavioral interventions</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Services not available/Ineffective</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Trauma/grief and loss</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Life skills/future planning</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Mental health medications</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Trustworthy adult/mentor</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Family therapy after aging out</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>ADHD/Bipolar disorder/Schizophrenia</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Substance abuse issues</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. *Respondents could indicate more than one unmet need.

Treatment Planning

Providers suggested that collaboration and using a team approach were important to the treatment planning process for youth aging out and transitioning to adulthood. Almost half (47%) of respondents reported collaborating with independent living coordinators, and 25% indicated that they incorporate community supports and referrals to adult services into the treatment planning process. One-third (33%) of respondents also reported using a team approach (e.g., Child to Adult Transition Teams or other type of multidisciplinary team) that involves youth, family members, and providers in helping youth transition to adulthood. Respondents suggested that teams met regularly to assess the strengths and needs of youth, in addition to establishing timelines for service delivery.

Available Resources for Young Adults Who Aged Out of Foster Care

Seventy-three respondents provided specific information on services and resources available to youth who have aged out and transitioned to adulthood. As shown in Table 7, only 37% of providers indicated that mental health and independent living services were available, and 23-27% reported the availability of services addressing education, housing, physical health care, and employment needs. To an even lesser extent, services to help youth find their birth families or locate other family members and friends (14%) were reportedly available as well as assistance with financial planning (12%).
Table 7. Resources Available to Youth Aged Out and Transitioned to Adulthood

<table>
<thead>
<tr>
<th>Available Resources*</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Independent living counselor/services</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Education</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Housing</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Physical health care</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Employment</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Family and friends location services</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Financial planning</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Internet and other media</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Substance abuse services</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Targeted case management</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Church/spiritual services</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Respondents could indicate more than one available resource.

More than half (56%) of the survey respondents commented that access to at least some services was limited or insufficient for reasons such as transportation, geographic location of services, wait lists, health insurance, and continuity of care. Transportation issues included problems traveling to work, school, and treatment appointments; and “many do not have vehicles.” This was exacerbated by services not being located within proximity of youth residences. In addition, providers indicated that the “wait lists can be long” for services such as housing and health care appointments, and that qualifying youth for services was a challenge due to changes or lapses in insurance coverage. One respondent wrote, “It would be helpful if these children could continue to get Medicaid until they have a job with insurance.” Others commented that multiple providers did not coordinate well with one another, and “There is no smooth transition to adult services.” Two respondents suggested that there is a “revolving door” of service providers and that “most children trickle through various case managers, counselors, foster parents, schools, etc.” which contributes to discontinuity of care.

Providers also commented on the difficulty of assuring service provision to youth who do not follow up with treatment or other resources after aging out. One respondent wrote, “most times these children have not followed through with therapy or targeted case management services” and another wrote, “most of them will feel that they don’t need any of ‘that stuff’” and “more than likely, that information [resources] will get thrown away.”

Connecting Youth to Resources

Seventy-eight respondents mentioned specific ways that they connect youth with resources available in adulthood. Table 8 reveals that almost half (49%) of respondents indicated that they assigned youth to an independent living coordinator or referred them to a case manager, targeted case manager, or counselor who oversaw the transition. Forty-six percent had community partnerships and made referrals to community agencies for continuation of care, 23% provided youth with materials or resources so that youth could seek services for themselves, and 17% of respondents worked collaboratively with youth to set up future appointments and services.
Table 8. Ways in Which Youth Aging Out and Transitioning to Adulthood are Connected to Resources

<table>
<thead>
<tr>
<th>Means of Connecting Youth with Resources*</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign an independent living coordinator/case manager/counselor</td>
<td>38</td>
<td>49</td>
</tr>
<tr>
<td>Make referrals for continuing care</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Provide resources to youth for community outreach</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Work with youth to schedule appointments/services</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Connect with family and friends as part of transition process</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Provide mental health assessment/treatment</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Multidisciplinary team for recommendations/follow up</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Encourage to join a church for support/services</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Guardian ad Litem program</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mentorship to the age of 23</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. *Respondents could indicate more than one means of connection.

Improving Experiences, Opportunities, and Support for Transitioning Youth

Sixty-nine respondents provided suggestions for improving experiences, opportunities and support for youth aging out and transitioning to adulthood. As seen in Table 9, respondents most often suggested that youth need mentorship, advocacy, and support that continue into their adult lives after transition (28%), and that independent living programs begin at a younger age, meet more often, and extend into adulthood (23%). Providing more hands-on or real world experiences for youth (17%), and a list of local resources and access to those resources (17%) also would be beneficial to youth. Increased funding and numbers of services (14%) and better training for professionals working with transitioning youth (12%) were also cited as areas warranting further attention. One respondent commented that although “there are a number of resources available to this population” they do not utilize them “due to their age and level of maturity.” This individual further wrote, “Many youth, though, accept the educational opportunities provided and work closely with their independent living specialist to make their transition as smooth as possible.”
Table 9. Suggestions for Improving Experiences, Opportunities, and Support

<table>
<thead>
<tr>
<th>Suggestions*</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentorship, advocacy, and support into adulthood</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Begin independent living programs at younger age, meet more often, extend into adulthood</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Provide hands-on/real world experiences</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Lists of/access to resources in local counties</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Increased funding and number of services</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Better/more training for professionals working with youth</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Have youth participate in transition process</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Greater focus on youth education</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Greater focus on vocational training/employment</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Additional training and support for foster parents</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Adequate, consistent mental health treatment</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Additional parenting from foster parents</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Increase team approach to serving youth</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Increase availability of transportation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Establish family and friends support</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Respondents could indicate more than one suggestion.

Summary and Recommendations

Provider survey respondents were individuals in professional positions where they primarily provided mental health counseling and case management services to youth aging out of foster care and transitioning into adulthood. Over three-quarters of the respondents reported that this population has needs and faces challenges in the areas of employment, education, mental health, housing, and finances. Substance abuse was also noted as a challenge by two-thirds of survey respondents. Almost half of the providers reported receiving training on working with transitioning youth; however, almost two-thirds identified additional training needs. The two most often mentioned training needs were being better informed of what community resources and services are available to youth, and learning what is being taught in the independent living classes. Other identified training needs focused on educational and vocational training options, the process to prepare youth for transition, and the barriers they experience in their transition from foster care into adulthood. Some respondents wanted additional training in all areas for this population.

Respondents indicated that primarily, the types of services available to this population of youth focused on issues related to mental health, independent living skills, education, housing, physical health care, and employment. A variety of evidence-based or best practices were reported as being utilized by survey respondents, including independent living skills, Cognitive Behavioral Therapy, trauma-focused therapy, solution-focused therapy, family team
conferencing or support teams, ensuring youth are connected to community resources, and client-centered practice. In addition, almost half of respondents reported collaborating with independent living coordinators and one-third noted that they utilize a team approach when working with youth transitioning from foster care into adulthood.

Despite the efforts described by survey respondents to effectively serve youth transitioning from foster care to adulthood, these youth still have needs that are not being met. Most often mentioned were mental health counseling and follow up and better behavioral interventions. Additional needs included addressing past trauma or grief issues, developing life skills, access to and inconsistency in taking mental health medications, and having adult mentors involved in the lives of these youth. In addition, access to some services can be limited or insufficient. Transportation was seen as a problem impacting access to work, school, and treatment appointments. Other barriers included qualifying youth for services due to changes in or lapses in insurance coverage, provider wait lists, and the geographic location of the services. Some respondents were not aware of the resources that were available.

In order to connect youth to resources from the adult system, survey respondents most often reported assigning youth to independent living counselors or case managers and making referrals for continuing care through established community partnerships. However, providers were also challenged to ensure that youth follow up with treatment or resources after aging out. Youth may not understand that they need to continue with treatment or they may experience discontinuity of care due to the reasons listed above.

Provider suggestions for improving the experiences, opportunities, and support for youth aging out of foster care included continuing supports into adulthood, implementing independent living programs with youth at a younger age, providing opportunities for more “real world” experiences for youth, providing lists of and access to local resources, and increasing funding and the availability of services.

Recommendations

- The CBC Partnership should, in collaboration with community providers, consider creating and maintaining an internet-based list of available services and resources within each county in Florida related to youth aging out of foster care and transitioning to adulthood. This list should include eligibility requirements for services to facilitate the treatment planning process.

- The CBC Partnership, child welfare agencies, and mental health service providers should consider developing and updating online training modules related to serving the specific needs of youth with mental health needs who are aging out of foster care and transitioning to adulthood with different tracks for providers and youth. Provider tracks could include such topics as available services, evidence-based or best practices, content of services offered, and techniques to motivate youth to participate in services. Youth tracks could offer the availability of services, methods of accessing services, and successful problem-solving techniques and coping skills to use when faced with barriers.

- Hands-on and real-life skills training and independent living skills training should be introduced at an earlier age to these vulnerable youth. This could increase the opportunities for successful transition due to increased exposure to and practice of these necessary skills. Also, by beginning this area of transition earlier, these youth
could possibly be placed on the waiting list for specific adult services in time to have the services available when they transition, thus reducing the amount of time without services.

- AHCA and the CBC Partnership should investigate how they could better ensure youth have appropriate housing and transportation when they transition out of foster care. Improving these two areas could greatly reduce stress and increase the likelihood of the youth staying connected and receiving services necessary for their stability and ultimate success as an adult.

- ACHA and the CBC Partnership should consider continuing care in the form of follow-up with the youth after they transition to adult services. This extended time could provide necessary support and guidance in navigating housing, transportation, education, employment, health, and behavioral health issues and services, ultimately increasing the overall lifetime success for these youth.

Findings – Foster Parent Interviews

Participants

Telephone interviews were conducted with 15 eligible foster parents who had cared for a 16-17 year old youth who was expected to age out of the system and received mental health services within the past year, or a youth that had already aged out and received mental health services during their last year in foster care. One to six foster parents from each of the six selected CBC lead agencies across the state participated.

Youth Demographics

All of the identified youth, except one, were currently living with the foster parents who were interviewed. The length of time that the foster parents had been caring for these youth ranged from one month to 14 years. Based on foster parent reports, the youth had a variety of presenting mental health related symptoms and diagnoses including Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, grief, loss, and separation issues due to parental death, separation, and abuse, anger, aggression, explosive behavior, depression, and social withdrawal.

Mental Health Services Received

Foster parents reported that the identified youth whom they had parented in the past year or were currently parenting had all received mental health services, including in-home and outpatient counseling, medication management, targeted case management, and behavior management. The majority of the services were provided in the foster home with some alternating sessions at school as part of either a therapeutic foster care or community-based counseling program ranging in frequency from one to two times per week. Medication management services were typically provided by a psychiatrist on an outpatient basis. In addition to the mental health services, two of the identified youth were reportedly receiving time-limited anger or behavior management through the juvenile justice system and one was receiving occupational and speech therapy.
Helpfulness of Mental Health Services

The majority of foster parents interviewed (n = 13) characterized the mental health services received by youth in their care as being very or somewhat helpful. One foster parent indicated that the services had not been helpful because they did not successfully improve the youth’s behavior or anger control. Another foster parent stated she could not adequately rate the helpfulness of the therapy received by the youth because the sessions were private. The most that this foster parent could relate was that “nothing has gotten worse.” Foster parents stated that the services had helped the youth in many ways, such as teaching appropriate skills to manage anxiety and anger, problem solving skills, methods to address past abuse and loss, building confidence, and improving social involvement. Those who had parented youth receiving psychiatric medication management stated that the medications had helped to alleviate presenting symptoms. Some of the foster parents discussed ways in which the services could have been more helpful to the youth, including having a greater impact on decreasing aggressive behaviors. One foster parent commented that counseling had not been as helpful for the identified youth or youth in general that she had cared for, possibly because often youth in foster care are not given a choice about participating in mental health services. Therefore, from this foster parent’s perspective, youth say in therapy what they think they need to say to get through a session and complete services without engaging in an effective manner.

Services to Help Prepare Youth for Transitioning Out of Foster Care

In general, findings indicated that the majority of the youth discussed in foster parent interviews had some contact with independent living services to help them prepare for aging out of foster care. Service and supports were provided primarily by either an independent living specialist, child welfare case manager, or both. It was also indicated that targeted case managers were a beneficial component of the support system for those youth receiving targeted case management. The degree of support and services received varied considerably depending on how long the youth had been living with the parent, the willingness of the youth to participate in services, and some geographic areas seemed to have a more robust array of services available to the youth, at least as it was described by the foster parent interviewees. In some cases, the foster parents reported that they did not have direct contact with the independent living provider and therefore did not have firsthand knowledge of the assistance that might or might not have been offered to the youth. Types of support received by youth involved in independent living services included an initial assessment of skills and needs, help applying for and obtaining a job, using public transportation, learning basic living skills, and managing money. One foster parent described the helpfulness of these services with the following statement:

They’ve come to the house and done individual classes with him...They’ve done education, helped him with a library card...They’ve showed him how to do that...He knows how to catch the bus, he has a bus pass now. So they did all those things and it helped him a lot.

In addition to these more common types of supports, one foster parent reported that she and the child welfare agency had helped the youth complete the immigration process to become a citizen of the United States. A primary function of independent living services seems to be to educate youth concerning supports that will be available after he or she turns 18 such as housing options, the Road to Independence Program, and the guidelines to qualify for these
supports. One foster parent indicated that the combination of a therapist helping the youth feel more comfortable in public and social situations and the independent living program assisting him with basic living skills improved the youth’s functioning. As the foster parent explained, “It is great…he is able to manage money, he is able to clean his room, do his laundry, ride the city bus and get out on his own and go places.”

In addition to independent living specialists and child welfare case workers, foster parents mentioned that school counselors and tutors assisted with helping youth progress academically and advance to the appropriate grade level to ensure that a youth is prepared to continue his or her education after high school. Guardians ad Litem (GAL) were also reported by some foster parents as being valuable to youth progress, pointing out that sometimes GALs are a consistent presence in a child’s life while in foster care even if the child moves from one home to another or has a change in case worker.

Even when youth had received independent living services or supports from a structured program, interview findings indicated that the foster parent was often the primary means of support and guidance for the child concerning learning how to take care of adult responsibilities such as applying for a job, managing money, obtaining a driver’s license and transportation, housekeeping, and personal hygiene. As one foster parent stated, “He gets an allowance when he’s with us and he’s used his allowance to pay his phone bill because I wanted him to try to start learning some money management. We also opened up a bank account for him.” Foster parents reported that supporting youth in these tasks often happens through modeling and instruction during day-to-day activities. As characterized by one foster parent, “She goes wherever I go, to the grocery store, shopping, to the malls, wherever I go she goes, so she learns that way.”

When the youth in care had siblings and extended family available, the foster parents who were interviewed also indicated a desire to help the youth stay connected, and they facilitated and participated in visits with family members.

**Mental Health and Independent Living Service Needs**

The majority of foster parents interviewed indicated that overall the mental health and independent living service needs of youth were being met and that the services were consistent with the identified needs. In general, foster parents also described having confidence that supports and services would be made available to the youth by the child welfare agency if other needs arose. Foster parents indicated that overcoming past abuse and loss and effectively dealing with feelings of anger, aggression, and depression are sometimes the greatest needs of these youth. Overall, it was also indicated that youth were receiving services to help with these issues. However, foster parents who thought that the youth needs were not being met stated that the youth in their home could benefit from more assistance with job training, such as a Job Corps program that the youth was not able to access and additional educational assistance for youth with learning disabilities or those lagging educationally for other reasons. Furthermore, educational and academic difficulties experienced by the identified youth and other youth whom foster parents had cared for was a consistent theme identified in the interviews. Another need that was reported by the majority of foster parents was assistance with transportation, including financial support to use public transportation and helping the youth get to and from school, work, and medical appointments. In addition, one foster parent stated that having a mentor that the youth could develop a positive relationship with might help him increase his social activities.
At the same time, it was evident that service provision varied. For example, some foster parents reported the helpfulness of youth receiving tutoring services and educational counseling, while at least one foster parent indicated that this type of academic assistance might have been helpful to the youth in her home who did not graduate from high school prior to aging out of foster care. One foster parent stated that engagement with a biological parent had served as a deterrent to a youth following up with potential supports, because the parent encouraged the youth to not participate. A youth’s attitude and behaviors toward services were also listed as challenges. Examples included the youth’s resistance or refusal to participate or engage in services, the youth’s perception that the services offered were not helpful, or the youth’s presenting symptoms such as aggression, social withdrawal, or explosive behavior interfering with their ability to benefit from services. Behaviors and attitudes such as “she just won’t listen,” “he goes sometime…but he just doesn’t participate,” and “they have sent him a letter here…he balls it up and throws it away” were described. One parent summarized a youth’s perception that the services were not helpful, i.e., “So far what he’s been exposed to he hasn’t been real impressed with.”

Foster parents who were reporting on young adults who had already transitioned out of foster care and into an independent living program indicated that one of the barriers to receiving mental health services after a young adult turns 18 is a lack of continuity between children’s mental health services and adult mental health services. One foster parent reported that the young adult still living with her after turning 18 faced a long waiting list at the adult community mental health agency that prevented him from receiving psychotropic medication prescribed while in foster care. In this example, a contributing factor was that even though the young adult was eligible for Medicaid, he could not continue with the child mental health provider because that provider did not accept the adult Medicaid plan.

**Future Plans**

Foster parents reported a variety of career interests that youth had identified, including military service, public service (i.e., policeman, fire fighter), veterinarian, attorney, working in the construction industry, working with computers, and owning a lawn business. In only five instances did foster parents specifically mention that the youth had voiced an interest in continuing their education either through college or technical school. Several foster parents commented that youth had discussed living on their own or moving in with a relative or girlfriend. One stated that the youth wanted to marry his current girlfriend. Finally, one foster parent was unaware of any future plans the youth had other than staying with the foster parent.

It was not apparent that many youth had taken steps toward investigating their fields of interest or that they had received any specific assistance in working toward the goals known to foster parents. One foster parent generally stated that Florida Youth SHINE and the Independent Living Program were assisting the youth with working toward a goal to attend college. Others stated that youth discuss college or career goals with the targeted case manager and/or therapist, and a few others indicated that the youth were not quite ready for that step. The two most tangible examples of youth beginning to investigate their future interests were of one youth who had briefly spoken to a police officer about the law enforcement profession and another who had been participating in the ROTC (Reserve Officer Training Corps) program in high school for several years to prepare for a military career. Regarding the ROTC program, the foster parent said, “It’s been a fantastic program for him. I think that’s the reason he stayed in school.”
Youth Successes in Preparing for Adulthood

“In order to be successful, you got to be around successful children, successful people,” was one foster parent’s philosophy of how to positively influence youth. This foster parent reported having older youth in her home who act as positive role models for the identified youth that is transitioning into adulthood. The youth not only learns from the foster parent, but also learns from these older youth in such areas as taking the bus and learning financial responsibility by shopping on the sale racks for clothing. Other areas of youth progress in preparing for adulthood that foster parents discussed included working part-time jobs or taking the initiative to apply for a summer job; learning how to cook, clean, iron, and properly attend to their personal hygiene needs; consistently taking prescribed medications on a regular schedule; and staying in high school or enrolling in night school. While three foster parents could not readily identify any successes their youth had experienced in preparing for adult responsibilities, one youth was described as becoming more independent and another was characterized as having the potential for success because “he is very strong-willed and strong-minded.”

Adult Support for Youth After Aging Out

It was evident from the interviews that foster parents felt a great sense of commitment to the youth in their care. The majority of foster parents said they would remain supportive in the lives of the identified youth after they age out of foster care, as evidenced by statements such as, “we tell them once we become your foster parents, that’s for life,” “you can be whatever you want to be… I am going to treat you just like I treat my own child,” “I always tell them that I am here for them,” and “I consider him as my son and I am there for him whenever he needs me.” In some cases it appeared that the foster parents were the only adults known to be a source of future support to these youth. However, in many cases there were other individuals who were identified as potential resources and positive influences for youth. These included family members such as siblings, nieces, nephews, aunts, grandparents, and family members of the foster parent; a church pastor; the independent living agency workers; and youth that had already aged out of foster care. In several cases, foster parents reported that youth family members were currently active and affirming influences in their lives. One foster parent did not know of any specific individual who could assist the youth with adult responsibilities after aging out of foster care.

Foster parents also spoke of adult supports for youth previously in their care who had aged out of foster care. It appeared that more often than not, these youth did not have consistent and positive adult influences in their lives after reaching adulthood. While one foster parent spoke of several youth who connected with a mother, sister, or grandparent, found employment, and were doing “pretty good,” only one youth went to college, and another “wound up in prison.” Otherwise, foster parents spoke of the absence of adults who could lend support or the presence of unstable adults (e.g., substance abuse issues) in the lives of these youth. In addition, foster parents commented on youth needing additional attention in high school to better prepare them for post-secondary education, the immaturity of youth inhibiting good decision making and judgment capacity, and youth becoming homeless after two or three months on their own.

Several foster parents suggested that youth are leery of connecting with adults due to the sheer number of people they have dealt with in the child welfare system or being inundated...
with services to the point that they “turn it off” resulting in a mindset that “they want nobody.”

Another foster parent said, “I think while they’re in our care, while they’re under age, they get…
all the support they need. But when they go out kind of on their own, it seems like they get
dropped a lot.” Finally, one foster parent said, “The kids that come in are very standoffish, they
don’t want those connections with adults. I guess they’ve had bad histories with adults.”

**Challenges Facing Youth**

When describing the current challenges facing identified youth in their transitions to
adulthood, foster parents most often mentioned a lack of motivation or refusing help, anger
management issues, and problems with continuing needed mental health medications. Foster
parents described some identified youth as having a lack of motivation to work or continue their
education, or as refusing services and offers of assistance. Behavior problems stemming from
poor anger management had reportedly resulted in one youth being expelled from school
and another youth’s behavior problems were thought to potentially inhibit his progress in
college. In addition, other identified youth reportedly refused to take their prescribed mental
health medications, took them inconsistently, or had difficulty obtaining their medication after
transitioning into the adult system due to a loss of Medicaid and changing providers. In one
case, the young adult that had recently aged out was evidently having to take less medication to
make it last until he could get in to see the doctor at a new provider in the adult mental health
system.

Another challenge facing identified youth according to foster parents was not knowing
what their future held. For example, one participant stated, “The uncertainty of his future was
really weighing on him and it stressed him pretty seriously this spring.” Finally, one foster parent
described a possible domino effect for a youth that had been denied a special diploma by the
school system. This would raise expectations for college success that the youth could not meet,
resulting in discontinuation of independent living benefits with no employment, which would
then increase the possibility of the youth committing a crime or living on the street. The foster
parent suggested that instead of imposing unrealistic expectations on youth, it would be more
productive to acknowledge this youth’s limitations and lend appropriate assistance to help
maximize his true potential.

It was evident that challenges similar to those already described also faced other
transitioning youth for whom foster parents previously had provided care. These included youth
refusing services possibly due to feeling “burned out” by being exposed to too many services
or adults in the child welfare system, discontinuing mental health medications sometimes due
to loss of Medicaid coverage, feeling uncertain about what their futures hold, lagging behind
in school and lacking motivation to continue with their education, and negative influences of
family members, boyfriends, or girlfriends.

**Support for Foster Parents**

In order to help ensure that youth are receiving all the services and support they need
in their journeys toward adulthood, it is important for their caregivers to receive support as
well. The majority of foster parents spoke of attending classes (in person and online) on topics
such as parenting and quality parenting, anger management, behavior management, stress
management, health and mental health issues, and sexual abuse. One foster parent said the
specific topic of youth aging out of foster care was addressed in classes and another said it was not. Some foster parents thought it was beneficial to network and talk with other foster parents at meetings or support groups sponsored by the foster parent association or other child welfare agencies in their geographic areas. Emphasizing the importance of participating in such gatherings, one foster parent said, “I know where to go if he needs services, but not all foster parents know that.” Another stated, “We have monthly foster care meetings. I’m disappointed that a lot of foster care parents do not [attend].”

Other types of support mentioned by foster parents included access to a support specialist or foster parent liaison for obtaining needed information, and drawing on previous professional experiences in the child welfare system. One foster parent apparently had specific conversations with the identified youth’s case worker, targeted case manager, and independent living program staff about how to help prepare the youth for adult responsibilities. However, another foster parent indicated being informed of what the independent living program was doing, but not receiving any “hands-on” training on how to specifically help the youth prepare for adulthood.

While many foster parents indicated not needing any additional support, others discussed areas where improvement was needed. One foster parent voiced a desire to be able to help youth with their education by stating, “I don’t know trig [trigonometry]” and “We need more support with their education. I think education is a big part of their life and a lot of them don’t care, they don’t want to go to school, there is no motivation there.” Another foster parent emphasized the need for foster parents to take a more hands-on approach especially with teens who lack basic daily living skills such as ironing, cooking, and cleaning, “You got to show them how, don’t just house them.” Yet another foster parent expressed the need for a closer relationship with the identified youth’s workers regarding the aging out process because she cannot answer the youth’s questions,

A lot of times I feel like I may be in the dark on some information that has been given to the child…so that would be very helpful if I was kind of included… and [I could] provide a more accurate response or have more available to offer the child.

**Foster Parent Suggestions for Improvement**

When asked for suggestions to improve the experiences, opportunities, and support for youth with emotional and mental health needs who are aging out of foster care and into adulthood, foster parents commented on the educational needs of youth, foster parent training and involvement, case worker experience, more applicable independent living services, and collaboration and coordination among child welfare professionals. As previously stated, foster parents indicated that more attention needs to be directed toward meeting the current educational needs of youth transitioning to adulthood and facilitating their pursuit of post-secondary education. This included special help if they are struggling with certain subjects, assistance with obtaining their GED, ongoing encouragement to continue with their education, and preparing youth for college by helping them to really earn their high school diploma instead of just giving it to them and thereby practically ensuring their failure in college.

Suggestions were also made to offer more help to foster parents. These included providing additional training to foster parents on better understanding the individualized mental health and medication needs of youth and how to help youth deal with their anger, encouraging foster parents to become more involved in the mental health treatment of youth by having
more contact with therapists and other service providers, and encouraging foster parents to become more involved with formal gatherings to talk with and gain support from other foster parents caring for teenage youth with mental health needs who are aging out of the system and transitioning to adulthood.

It was also noted that case workers “coming straight out of college” might not have the necessary knowledge and experience to work with teens with mental health issues approaching adulthood. It was suggested that case workers have more training in working with this population of youth and possibly visiting group homes and observing them to gain greater insight into their needs and experiences.

Foster parents also spoke of making the independent living classes more applicable to the needs of youth aging out of foster care, including teaching them how to develop a budget, manage their money, pay bills, and keep their house clean. One foster parent proposed weekly contact between youth and independent living staff regarding such daily living activities starting when the youth turns 17. In addition, it was suggested that youth be educated on their mental health needs and especially their medication needs. One foster parent said, “Oftentimes they are handed a pill or they’re handed some type of medicine but they don’t even know what it is for” and “It is really important that they have some kind of trust in the mental care provider that they can reach out to when they have questions on their medicine.”

Finally, there was the suggestion to make the system “less disjointed” so foster parents could deal with one agency for everything and that there be more collaboration and coordination among all the systems serving this population of youth, especially as it relates to following them after they age out of foster care so they can access the help they need to be successful adults.

Summary and Recommendations

Although foster parents generally indicated that mental health and independent living services were available to youth preparing to transition out of foster care, they also noted unmet needs and challenges that this population faces in preparing for adulthood. Mental health services received included in-home and outpatient counseling, behavior management, targeted case management, and medication management that were primarily provided through a therapeutic foster care or community-based counseling program. Furthermore, a majority of the foster parents reported the mental health services to be very or somewhat helpful at meeting youth needs. Foster parents also stated that mental health services could be more beneficial if youth had control over participating in counseling or not and if treatment had more of an impact on decreasing aggressive behavior.

In addition, the majority of identified youth had participated in independent living services. Foster parents reported independent living specialists, child welfare and targeted case managers, school counselors, tutors, and Guardians ad Litem to be beneficial components of youth support systems. Youth in their care had received assistance and education concerning how to apply for and obtain a job, use public transportation, complete basic living and hygiene tasks, meet academic requirements, and manage money. Foster parents also described how the mental health and independent living services can complement each other and typically the more successful a youth has become at managing adverse behavioral and emotional symptoms positively impacts the success of independent living services.

In addition to formal services, it became clear that foster parents are often the primary means of support and guidance for youth in their homes. Much of this teaching happens
through typical daily activities where the foster parent models for the youth how to manage adult responsibilities. Foster parents expressed an ongoing commitment to not only youth currently in their homes, but to those who had previously aged out of foster care with whom they remain in contact. Unfortunately, foster parents reported youth typically do not have a strong network of support after they leave foster care. This reality seems partially due to an actual lack of available support and partially due to a young adult’s resistance to staying or becoming connected to adults who are viewed as a part of the child welfare system.

Concerning the ongoing needs of youth aging out of foster care, foster parents described two common challenges: overcoming the impact of abuse and loss, and learning to manage feelings of anger and depression. Most of the youth currently or formerly cared for by the foster parents were said to be behind academically typically due to developmental delays or disorders, learning disabilities, or the interference of behavioral and emotional symptoms. While some of the youth had received assistance academically, not all of the youth received the degree or type of services needed to help them succeed. This seemed to be caused by the lack of resources in some service areas. Furthermore, foster parents referred to academics as an area that they are not always able to provide as much assistance to youth as they would like if they do not have knowledge of a specific subject. Understandably, foster parents expressed concern about the long-term impact that educational delays and failures can have on a young adult’s future. Additional needs were related to assistance in and education about the use of psychotropic medication and managing medication during and after foster care. Foster parents indicated they could also benefit from more training related to the mental health and medication needs of teenage youth and young adults. It was suggested that case workers also need more training specific to working with youth aging out of foster care with mental health needs.

**Recommendations**

- The CBC Partnership and mental health service providers should collaborate with child welfare agencies, foster parents, and educational providers to develop integrated intervention plans specifically targeted toward supporting the individualized educational needs and goals of youth and addressing barriers to achieving these goals.

- The CBC Partnership, in collaboration with child welfare agencies, should develop creative ways to strengthen the network of supportive adults and peers available to youth once they age out of foster care. This should include not only organizations that are specifically intended for individuals who have aged out of foster care, such as Florida Youth Shine and Connected by 25, but also entities that are not specific to foster care such as peer support and mentor groups on college campuses and those that relate to the specific career or personal interests of youth.

- The CBC Partnership, mental health service providers, and child welfare agencies should work together to ensure that interdisciplinary training and support specific to working with teenagers with mental health needs is available and easily accessible in all service areas to foster parents, child welfare case managers, independent living specialists, and all other child welfare staff in order to serve these youth in a more collaborative and coordinated manner.

- The CBC Partnership should partner with AHCA and the adult mental health service system to ensure that adequate transition plans and agreements are in place so that
no young adult aging out of foster care experiences a significant lapse in or denial of mental health services including medication management.

Discussion

The current study was intended to gain a deeper understanding of the needs and experiences of youth served under the CW-PMHP who are aging out of foster care and how to improve the service and support systems to better meet their needs. The findings were consistent with the literature reviewed on this population of youth and young adults.

While overall it was indicated that youth aging out of foster care are receiving mental health and independent living services that are helpful, the complex and persistent needs experienced by youth require more individualized and comprehensive services that continue to be available once they have aged out of foster care. Furthermore, challenges reported by providers and foster parents such as academic delays, substance abuse, developmental and mental health disorders, and the experience of abuse, loss, and trauma are not easily or quickly overcome and might require multiple types of coordinated interventions. For example, to address academic challenges a youth might require a tutor, peer mentor, and special education classes in conjunction with support to the foster parent to address behavioral impacts.

In addition to formal supports, the benefit of informal supports such as the guidance offered by foster parents on a routine basis to help youth learn how to take care of adult responsibilities was emphasized. It was also stated that youth who have been in foster care and experienced numerous losses are not readily open to staying or becoming connected with individuals or programs that are viewed as being associated with the child welfare system. Because of this possible resistance, it is important for individuals trying to help young adults to identify and advocate for supports that are not necessarily tied to the child welfare system such as peer and mentor groups in educational settings, and social groups and clubs associated with the career and personal interests of youth.

Even though providers suggested that a multi-disciplinary team approach is beneficial, it was not evident that foster parents are engaged as much as possible in the mental health treatment and independent living service planning for youth. This coordination seems necessary to help foster parents, mental health providers, and independent living specialists identify how to best complement the supports, guidance, and treatment each person is offering. Furthermore, since it was suggested that providers, foster parents, and case workers could benefit from more training related to the specific needs of youth with mental health issues who are aging out of the foster care system, coordinated training efforts might have the greatest impact.

Finally, a coordinated effort between the children's mental health and adult mental health systems seems crucial to ensure that young adults are receiving the mental health services they need after turning 18 years old without significant or extended gaps in care.
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