

Mental Health and Substance Use Problems and Service Utilization by Transition-Age Foster Youth: Early Findings from CalYOUTH

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Introduction¹

A growing body of research has shown that youth transitioning to adulthood from the foster care system exhibit rates of mental health disorders that are much higher than their same-age peers (Havlicek, Garcia, & Smith, 2013). It is less clear whether these young people are more likely than their peers to suffer from substance use disorders, though many of them do use substances in harmful ways (Keller, Salazar, & Courtney, 2010). Given their trauma histories, it is not surprising that youth in care often have mental health problems when they enter care. However, research also suggests that the instability they often experience while in care can exacerbate these problems (Rubin, O'Reilly, Luan, & Localio, 2007).

¹ Disclaimer: The findings reported herein were performed with the permission of the California Department of Social Services. The opinions and conclusions expressed herein are solely those of the authors and should not be considered as representing the policy of the collaborating agency or any agency of the California government.

Efforts to support successful transitions to adulthood for youth in foster care should take into account the prevalence of mental health and substance use disorders among this population. Aside from the debilitating effects of these disorders themselves, having a mental health or substance use problem can limit the ability of young people to continue their education, develop a positive employment history, and acquire and maintain supportive relationships, all of which are important tasks during the transition to adulthood (IOM & NRC, 2014). Unfortunately, prior research has shown that the transition to adulthood is associated with discontinuities in the provision of mental health services to youth who leave care. This occurs because they become ineligible to use child-serving systems and must learn to rely on adult-serving systems; in states that allow youth to remain in foster care past age 18, this appears to be less of a problem (Courtney & Dworsky, 2006; Havlicek, Garcia, & Smith, 2013).

Youths' struggles with mental health and substance use problems are of particular concern in states that choose to extend foster care to age 21, per the provisions of the Fostering Connections to Success and Increasing Adoptions Act (Public Law 110-351)(Courtney, 2009). Those jurisdictions are responsible for caring for young adults while supporting them in their work and education; those jurisdictions must also address medical conditions that get in the way of work and education. Undiagnosed or untreated mental health conditions may contribute to behaviors that can put youths' eligibility at risk.

This report examines mental health and substance use problems of and related services provided to young people participating in the California Youth Transitions to Adulthood Study (CalYOUTH). The study is following young people making the transition to adulthood from California's foster care system in the context of the state's new program of extended foster care (Courtney,

Charles, Okpych, Napolitano, & Halsted, 2014). Based on data collected from the youth, we describe the prevalence of current mental health and substance use disorders, receipt of mental health and substance abuse treatment services, use of psychotropic medication and youths' experiences with those medications, and selected predictors of service receipt. Our findings have implications for the delivery of mental and behavioral health services to transition-age youth involved with the foster care system.

Summary of the CalYOUTH Study Methods

The California Youth Transitions to Adulthood Study is a multicomponent study that aims to understand the impact of extended foster care on the support that youth receive and their outcomes in early adulthood. This report draws on data from the baseline interview of a longitudinal study of adolescents transitioning out of foster care. The youth interviews include responses from 727 adolescents in California foster care. Youth were eligible to participate in the study if they were between 16.75 and 17.75 years of age at the time of the study and had been in the California foster care system under the supervision of county child welfare agencies for at least six months. Reflecting California's county-administered child welfare system, we stratified our sample to overrepresent counties with smaller populations in order to better understand how county context is associated with service receipt and youth outcomes. Sample weights have been applied in the analyses presented here; therefore, responses are representative of the general population of California youth in foster care. CalYOUTH participants were asked questions on a wide range of topics. They will be interviewed again at ages 19 and 21, when some youth will remain in care through the extended foster care program. Just over 95 percent of the eligible youths ($n = 727$) completed the baseline survey. Thus, this report provides a statewide picture of older adolescents in foster care.^{2,3}

² For more information on the study design, refer to Courtney et al. (2014).

³ Reported population percentages are weighted to generalize to the statewide population of youth who fit the CalYOUTH sample criteria, whereas reported frequencies are unweighted. Unless otherwise noted, differences between subpopulations discussed in this report are statistically significant at $p < .05$.

During the baseline interview we assessed the mental health status of youth using the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID) (Sheehan et al., 1998; Sheehan et al., 2010) and assessed suicidal ideation and attempts among youth using selected questions from the Composite International Diagnostic Interview (CIDI; World Health Organization, 1998). The MINI-KID is a brief structured diagnostic tool used to assess DSM-IV and ICD-10 psychiatric disorders in children and adolescents. We also asked the youth a series of questions about the mental health and substance abuse treatment services they received, including their use of psychotropic drugs. Many of these questions were taken directly from the National Longitudinal Study of Adolescent Health (Add Health). Add Health is a longitudinal study of a nationally representative sample of US adolescents in seventh through twelfth grade during the 1994–95 school years. Add Health study participants have been interviewed four times since the first survey, with the most recent interview taking place in 2008 (Harris, 2013). Unless otherwise noted, comparisons of CalYOUTH survey responses to those from the general population of 17-year-olds are based on Add Health data. Questions about mental and behavioral health and service receipt were administered using audio-enhanced, computer-assisted self-interviews (ACASI). ACASI is a state of the art procedure for asking sensitive questions in a respectful and confidential manner. Youth were provided headphones and a laptop computer so they could listen and respond to questions privately without involvement of an interviewer.

Overview of the Youth Sample

We begin with a brief description of the adolescents participating in the youth survey (see Table 1). The youth were somewhat more likely to be female, are racially and ethnically diverse, and their age reflects the

Table 1. Demographic and Background Characteristics of Youth (*n* = 727)

Age (approximate mean age, years)	17.5
	%
Female	59.4
Race or ethnicity	
White	17.8
African American	17.6
American Indian/Alaskan	0.5
Asian/Pacific Islander	2.0
Multiracial	15.5
Hispanic	46.7
Other	–
Current living arrangement (%)	
Nonrelative foster home	44.4
Relative foster home	18.4
Group care or residential treatment	24.1
Legal guardianship	6.3
Adoptive home	1.9
Independent living arrangement	2.5
Other ^a	2.5
Parent of a child	7.4
Sexual orientation	
100% heterosexual	74.4
Mostly heterosexual	8.5
Bisexual	8.0
Mostly homosexual or gay	2.5
100% homosexual or gay	2.8
Not sexually attracted to either males or females	0.8
County group (%) ^b	
Rural/mostly rural	4.7
Urban	20.7
Large urban	43.5
Los Angeles County	31.1

Note: Weighted percentages.

^aThe “other” category includes court-specified placements, transitional housing, youth who had runaway status at age 18, and a general “other” category.

^bCounties were categorized as follows: Rural/mostly rural = counties with no population center over 50,000; urban = counties with at least one population center over 50,000, but none over 250,000; large urban = counties with at least one population center over 250,000; and Los Angeles County.

Note: Percentages may not sum to 100 due to missing data on some items.

study's sampling criteria.⁴ While most of the youth resided in family or family-like settings at the time of the interview, about one-quarter were in some kind of group or institutional living arrangement. Most youth live in large urban counties, but rural counties—accounting for 27 of the state's 58 counties—are home to nearly five percent of CalYOUTH participants. Table 1 also provides data on the self-reported sexual orientation of CalYOUTH participants, since sexual minority status has been found to be a marker for increased risk of experiencing mental illness (Mustanski, Garofalo, & Emerson, 2010). About three-quarters of the youth (74.4%) reported being “100% heterosexual” while the remainder reported some other sexual orientation (22.6%), or did not answer the question about sexual orientation (4%).⁵

Prevalence of Mental Health and Substance Abuse Disorders

Using youths' self-report of current symptoms, we assessed the prevalence of selected mental health and substance use disorders among the baseline CalYOUTH study participants (see Table 2).⁶ In some cases, youth refused to answer a question or responded that they did not know the answer. In some instances, these missing data mean that we cannot reach a definitive diagnosis based on MINI-KID diagnostic criteria. For the purposes of reporting prevalence rates here, we take the conservative approach of reporting a positive diagnosis only for those youth who answered all of the questions needed to conclusively reach such a diagnosis using MINI-KID criteria. Therefore, it is important to note that some of the youth who are categorized as not having a particular disorder may in fact have that disorder. However, they are categorized otherwise because of missing data. We provide a column in Table 2 to show

how many and what percentage of youth with a negative diagnosis fit this description. The most prevalent mental and behavioral health disorders were major depression and dysthymia, mania and hypomania, psychotic disorders, substance abuse and dependence, and alcohol dependence.

Compared to males, females were more likely to report symptoms consistent with current major depression (25.2% vs. 13.5%), dysthymia (9.4% vs. 4.9%), and PTSD (10.6% vs 2.7%). There were no statistically significant racial or ethnic differences in prevalence rates. Overall, over two-fifths of the youth ($n = 314$; 41.2%) reported symptoms consistent with one of the mental health disorders we assessed and nearly one-quarter ($n = 197$; 24.8%) reported symptoms consistent with a substance use disorder, and about one-seventh ($n = 113$; 13.6%) reported both. Fifty-three percent ($n = 404$) of CalYOUTH participants were found to have a positive diagnosis for one or more current mental and behavioral health disorders, with females receiving a positive diagnosis more often than males (57.5% and 46.9%, respectively). Sexual minority youth were more likely than those who reported being 100% heterosexual to report symptoms consistent with one or more mental health or substance use disorders (73.7% and 47.1% respectively).

We asked CalYOUTH participants two questions about their suicidal ideation and behavior: “Have you ever felt so low you thought a lot about committing suicide?” and “Have you ever attempted suicide?” Over two-fifths of the youth who responded to the question about past thoughts of suicide said that they had experienced such thoughts ($n = 311$; 44.4%) and about one-quarter of those who responded to the question about suicidal behavior indicated that they had attempted suicide in the past ($n = 184$; 26.3%).⁷ Females (51%) were much

⁴ Most of the youth were 17 years old (92.6%), although some youth were 16 (6.1%) and a few of the youth were 18 (1.3%).

⁵ For the purposes of this report, we refer to youth who reported a sexual orientation other than “100% heterosexual” as “sexual minority youth.”

⁶ The disorders we chose to assess are those most commonly experienced by older adolescents, but exclude some rare disorders, such as agoraphobia and Tourette's disorder.

⁷ Eight CalYOUTH participants (1%) were not asked the questions about suicidal ideation and behavior due to an error in the computer-assisted interview schedule that was fixed early in the study field period. An additional 18 youth (2.5% of the sample) answered “don't know” or refused to answer the question about suicidal ideation and a similar number ($n = 19$; 2.6%) did so for the question about suicidal behavior.

Table 2. MINI-KID Diagnosis Results (n = 719)

	Positive diagnosis		Negative diagnosis		Don't know/refuse ^a	
	#	%	#	%	#	%
Major depressive episode	152	20.5	567	80.5	50	8.8
Dysthymia	57	7.6	662	92.5	29	4.4
Manic episode	63	8.3	656	91.7	112	17.1
Hypomanic episode	29	4.1	690	95.9	114	16.5
Hypomanic symptoms	55	7.2	664	92.9	112	16.9
Social phobia and anxiety	42	5.5	677	94.5	59	8.9
Obsessive-compulsive disorder	40	5.5	679	94.5	74	10.9
Posttraumatic stress disorder	56	7.5	663	92.6	51	7.7
Alcohol dependence ^b	75	8.9	644	91.1	32	5.0
Alcohol abuse	28	3.5	616	87.7	27	4.4
Substance dependence (nonalcohol)	81	10.5	638	89.5	49	7.7
Substance abuse (nonalcohol)	83	10.8	636	89.2	41	6.4
Attention deficit hyperactivity disorder	50	5.7	669	94.3	29	4.8
Conduct disorder	34	4.9	685	95.1	36	5.3
Oppositional defiant disorder	53	7.4	666	92.6	35	5.3
Psychotic disorder (current)	55	7.8	664	92.3	51	7.7

Note: Unweighted frequencies and weighted percentages.

^aThe absence of affirmative responses to all items necessary for a positive diagnosis resulted in a negative diagnosis, even when this was the result of “Don’t know/refuse” responses. The “Don’t know/refuse” columns indicate the number and percentage of youth who received a negative diagnosis due to one or more “Don’t know/refuse” responses.

^b Respondents in this category met the criteria for alcohol dependence, which preempts alcohol abuse, and were therefore not assessed for alcohol abuse.

more likely than males (25.9%) to report past suicidal ideation. Females (29.9%) were also more likely than males (14%) to report past suicide attempts. Consistent with prior research on the general population of adolescents (Blum et al., 2000), blacks (23.6%) were much less likely than other youth (46.8%) to report past suicidal ideation and blacks (10%) were also less likely than other youth (28.4%) to report past suicide attempts. Also consistent with prior research (Russell, 2003), sexual minority youth were more likely than those who reported being 100 percent heterosexual to report past suicidal ideation (64.4% and 34.1%, respectively) and past suicide attempts (46.5% and 16.6%, respectively). Although there are no directly comparable figures available for the general population of 17-year-olds in the US, the national

Youth Risk Behavior Survey, administered every two years to ninth through twelfth grade students in public and private schools throughout the United States, asks youth about suicidal thoughts and behavior. In the 2011 survey, 15.8 percent of respondents reported having seriously thought about suicide in the prior 12 months and 7.8 percent reported having attempted suicide at least once in the prior 12 months (Center for Disease Control and Prevention, 2014)

Receipt of Mental Health and Substance Abuse Treatment Services

We asked several questions to assess youths’ receipt of mental health and substance abuse treatment services. Specifically, to assess receipt of mental health services

we asked if in the past year the youth had received psychological or emotional counseling, received medication for their emotions, and whether they had received psychiatric hospitalization. We also asked if in the past year they had attended a drug abuse or alcohol abuse treatment program. Over half of study participants had received counseling in the past year ($n = 406$; 54%), about three times the rate in the general population, with females (60.3%) being more likely to receive counseling than males (44.8%). Sexual minority youth (68.2%) were more likely than youth who identified as 100% heterosexual (48.8%) to have received counseling. Ten percent ($n = 71$) of all youth reported receiving psychiatric hospitalization in the past year and 29.1 percent ($n = 220$) had received psychotropic medications, with no differences by sex in the receipt of these services. However, sexual minority youth were more likely than youth who identified as 100 percent heterosexual to have received psychiatric hospitalization (15.7% and 8.4%, respectively) and were also more likely to have received psychotropic medications (36.6% and 25.4%, respectively). About one-fifth ($n = 124$; 18.8%) of the youth reported attending a substance abuse treatment program in the past year, about ten times the rate in the general population, with males (23.4%) being more likely to have attended than females (15.6%). There were no statistically significant racial or ethnic differences in substance abuse services receipt, nor were there differences by sexual orientation.

In recent years, observers have drawn attention to the use of psychotropic medications with children and youth in foster care, noting that these medications are used at rates higher than in the general population (about 4%), in some cases in inappropriate ways (Leslie et al., 2010; Raghavan et al., 2005). California has been involved in efforts to improve the use of psychotropic medications with foster children, enacting legislation in 1999 to create court oversight of their use. More recently, California's Departments of Social Services and Health Care Services have begun

a quality improvement project in response to the Congressional mandate that states adopt protocols for the appropriate use and monitoring of psychotropic medications administered to children in foster care. We asked a series of questions of the young people participating in CalYOUTH who indicated that they had recently received psychotropic medications. They were asked how strongly they agreed with the following statements regarding their medication use:

- “My medicine improves my mood, helps me concentrate, or helps me behave better.”
- “I get along better with people when I am on medication.”
- “My medicine gives me bad side effects.”
- “For me, the good things about medication outweigh the bad.”
- “When deciding to give me medicine, my doctor listens to what I have to say.”
- “If I take medication it's only because of pressure from other people.”

Table 3 summarizes the youths' responses to these questions, grouping their responses into categories of “strongly agree or agree,” “neither agree nor disagree,” and “disagree or strongly disagree.” The responses provide some insight into the wide range of experiences youth have with using medication. With respect to their engagement in decision making about their use of psychotropic medications, most of the young people report that they feel included by their physician in such decisions and most do not feel that they are only using medications for their emotions because of pressure from others. However, a significant proportion of these youth nevertheless express some level of concern about the effects these drugs have on their lives. Perhaps most tellingly, over thirty percent of the youth do not believe that the good things about the medication outweigh the bad.

Table 3. Experiences with Psychotropic Medications ^a		
	#	%
Received medications for emotions in past year	220	29.1
Medicine improves mood, helps concentrate, or helps behave better		
Strongly agree or agree	115	51.0
Neither agree or disagree	45	21.0
Disagree or strongly disagree	60	27.9
Get along better with people when on medication		
Strongly agree or agree	82	36.7
Neither agree or disagree	64	28.8
Disagree or strongly disagree	72	33.9
Medicine gives bad side effects		
Strongly agree or agree	63	30.1
Neither agree or disagree	50	20.5
Disagree or strongly disagree	107	49.4
Good things about medication outweigh the bad		
Strongly agree or agree	92	40.4
Neither agree or disagree	58	27.8
Disagree or strongly disagree	66	30.2
Doctor listens, when deciding to give medication		
Strongly agree or agree	167	77.6
Neither agree or disagree	23	10.8
Disagree or strongly disagree	28	11.0
Only take medication because of pressure from other people		
Strongly agree or agree	39	17.3
Neither agree or disagree	36	17.0
Disagree or strongly disagree	142	64.6

Note: Unweighted frequencies and weighted percentages. Some percentages do not total 100% due to rounding and responses of “don’t know” or “refused.”

^a Less than two percent of respondents answered “don’t know” or “refused” to any of these items.

Which Youths Receive Mental Health and Substance Abuse Treatment Services?

Ideally, mental health and substance abuse treatment services are provided to those most in need of such services. In order to get a better sense of the targeting of services in California, we assessed the extent to which youth who reported symptoms consistent with mental health or substance use disorders had received services in the past year. Table 4 shows the number and

percentage of youth who received different kinds of services among those whose self-reported symptoms indicate a current mental health or substance use disorder. For example, Table 4 indicates that about two-thirds of youth who reported current symptoms consistent with one or more of the mental health disorders we assessed reported receiving psychological or emotional counseling at some point in the past year. If we include psychiatric hospitalizations and receipt of psychotropic medications, over seventy percent of the CalYOUTH participants who reported one or more current mental

Table 4: Receipt of Services Given Positive Diagnosis of Current Disorder		
Youth with MINI-KID Current MH Diagnosis (n=314; 41.2%)	#	%
During past year...		
Received psychological or emotional counseling	217	67.1
Received medication for emotional problems	124	61.9
Psychiatric hospitalization	46	15.3
Any of the above services	228	70.3
Youth with MINI-KID Current AODA Diagnosis (n=197; 24.8%)	#	%
During past year...		
Attended drug or alcohol abuse treatment program	70	39.9
Received any AODA or MH service	149	75.5

health disorders had received some kind of mental health service in the prior year. In contrast, only about two-fifths of the youth who reported symptoms consistent with a current substance use disorder reported attending a substance abuse treatment program in the past year.

To look more broadly at the services youth with substance use problems might have come into contact with, we assessed the extent to which such youth had attended substance abuse treatment, received psychological or emotional counseling, received medications for their emotions, or entered a psychiatric hospital in the past year. Fully three-quarters of youth with a self-reported substance use disorder received at least one of these services, though our data cannot shed any light on whether the mental health services they received addressed their substance use problems.⁸

Ideally, sex, race, sexual orientation, and where youth happen to live should not influence whether they receive needed services. To provide a more in-depth assessment of the targeting of mental health and substance abuse treatment services, we developed statistical models of how youths' sex, race, sexual orientation, and geographic location relate to their receipt of services, controlling for the presence of symptoms consistent with a mental health or substance use disorder. We estimated logistic regression models predicting (1) receipt in the past year of one or more mental health services (i.e., counseling, medication, and psychiatric hospitalization) and (2) having attended an alcohol or drug abuse treatment program in the past year. In the model predicting mental health service receipt, we included as potential predictors youths' sex, race, sexual orientation, a measure of the urbanicity of the youth's placing county, and whether the youth reported symptoms consistent with a current mental health disorder. In the model predicting receipt of alcohol or drug abuse treatment, we included as potential predictors the same demographic characteristics and whether the youth reported symptoms consistent with a current substance use disorder. Counties were categorized as follows: rural/mostly rural = counties with no population center over 50,000; urban = counties with at least one population center over 50,000, but none over 250,000; large urban = counties with at least one population center over 250,000; and Los Angeles County. The categorization of counties was intended to capture potential differences between counties in availability of services associated with the economy of scale needed to provide services. Counties with very small populations may have a particularly difficult time providing services to this population since they never have more than a handful of youth in care and in some years they have no youth in care. Counties that are heavily urbanized may have the additional advantage of public transportation systems that can make

⁸ Placement in group care might also be considered a form of mental health or substance abuse treatment. To assess the potential impact this might have on receipt of services, we treated all youth in group care at the time of our interview as receiving mental health and substance abuse treatment services, regardless of their answers to our questions about direct receipt of the specific mental health and substance abuse services. Under this scenario, the percentage of youth with a current mental health disorder who received some kind of mental health service in the past year increases slightly to 73.9 percent. The percentage of youth who reported a current substance use disorder that received a mental health or substance abuse service in the past year, or lived in group care, was 78.7 percent.

accessing services easier for youth and their caregivers. We treat Los Angeles County separately because it accounts for about one-third of transition-age youth in foster care in California.

We found sexual orientation and mental health status to be associated with receipt of mental health services in the past year. All else being equal, reporting a sexual orientation other than 100 percent heterosexual increased the estimated odds of receiving mental health services by about three-quarters (Odds ratio ≈ 1.75 ; $p < .01$). Having self-reported symptoms consistent with a current mental health disorder more than doubled the estimated odds of receiving services (Odds ratio ≈ 2.06 ; $p < .001$). Being male was associated with a reduction in the estimated odds of receiving mental health services (Odds ratio = $.74$), but this difference only approached statistical significance ($p \approx .08$). Although some research on teens suggests that boys may be less willing than girls to use mental health services (Chandra & Minkovitz, 2006), recent research on receipt of mental health services among youth in foster care has not found a relationship between gender and use of services (Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010). Race and the county placing the youth were not associated with self-reported mental health service receipt.

Youths' sex, the presence of a self-reported substance use disorder, and placing county were all associated with the estimated odds that youth attended an alcohol or drug abuse treatment program in the past year. All else being equal, being male increased the odds of having received this service in the past year by over four-fifths (Odds ratio ≈ 1.87 ; $p < .01$). Youth who reported symptoms consistent with a current substance use disorder had estimated odds of attending a treatment program that were nearly five times higher than those for youth without a disorder (Odds ratio ≈ 4.81 ; $p < .001$). Lastly, all else being equal, living in Los Angeles County as opposed to any of the other county categories more than doubled the estimated odds of receipt of substance abuse treatment (Odds ratio ≈ 2.48 ; $p < .001$).

Study Limitations

Before discussing the implications of the CalYOUTH findings presented here, it is worth noting limitations of our data. While CalYOUTH provides information from a representative sample of 17-year-olds in care in California, the prevalence of mental health and substance use disorders and receipt of relevant services among youth in other states may differ from the estimates in this report. Our MINI-KID measures of mental health and substance use disorders are based on DSM-IV and ICD-10 criteria, and we collected this information using state-of-the-art ACASI methods that should reduce bias in the responses of our study participants. Nevertheless, these are self-report data and a full assessment of the mental health and substance use of these young people might in some cases lead a trained clinician to a different conclusion than we reached using the MINI-KID. We asked the youth about commonly provided mental health services and substance abuse treatment, but it is possible that our questions did not capture all such services. Moreover, our data do not measure the quality or effectiveness of the services the youth reported receiving. Lastly, while the CalYOUTH sample is relatively large compared to other studies of transition-age youth in foster care, it is possible that some differences between subgroups in the prevalence of disorders and receipt of services that were not observed to be statistically significant in this study would be found to be significant had we been able to collect data from a larger sample of youth. For example, our measure of sexual orientation does not differentiate between different types of sexual minority youth (e.g., bisexual youth versus youth who are not attracted to either sex) because the size of our sample is not large enough to allow us to make such distinctions.

Summary and Implications

Consistent with prior research on transition-age youth in foster care, the overall prevalence of mental health and substance use disorders among CalYOUTH

participants is high and warrants attention from child welfare administrators, social workers, and caregivers (Havlicek et al., 2013). Over two-fifths of the youth reported symptoms consistent with one of the mental health disorders we assessed and nearly one-quarter reported symptoms consistent with a substance use disorder. Females were at higher risk for depressive disorders and PTSD. Females were also at higher risk of suicidal ideation and behavior; about half of the females reported thinking a lot about suicide in the past and about three in ten had attempted suicide. Black youth were much less likely than other youth to have thought about or attempted suicide. Sexual minority youth were much more likely than youth who identified as 100 percent heterosexual to report a mental health or substance use disorder, suicidal thoughts, and attempted suicide.

Most youth who reported current mental health problems reported having received some type of mental health service in the past year, most commonly counseling. In contrast, less than half of the youth that reported substance use problems had attended an alcohol or substance abuse treatment program in the past year. Nearly three in ten CalYOUTH participants reported having received psychotropic medications in the past year. While they generally report that they are involved in the decision making around the use of such medications, and most of them report some benefits of the medications, nearly one-third report some form of dissatisfaction with their use. Encouragingly, the need for both mental health and substance abuse treatment services is strongly associated with their use. However, even after controlling for the current presence of a disorder, sex and sexual orientation appear to be associated with whether youth receive services; compared to females, males are more likely to receive alcohol or substance abuse treatment and may be less likely to receive mental health services. Sexual minority youth are more likely than heterosexual youth to receive mental health services. In addition, where youth live affects their likelihood of receiving treatment for a substance use problem, with youth in Los Angeles County being much more likely than their peers elsewhere in California to receive such help.

These findings have implications for service delivery in California, and perhaps elsewhere, and provide directions for future research. Given the prevalence of mental health and substance use disorders among these youth, child welfare agencies should pay special attention to the behavioral health service needs of youth approaching the age of majority in care. In particular, routine periodic screening for mental health and substance use disorders should be common practice when working with older youth in foster care. Close collaboration between health and behavioral health care systems and providers, schools, and the child welfare system will also help ensure that the behavioral health needs of youth in foster care are identified and that needed services are provided. States extending care to age 21 should anticipate the need to address youths' behavioral health in order to help youth take full advantage of the opportunities available to them during their stay in extended foster care. A plan to transition to adult service systems will be needed for many of these youth, lest there be unneeded and potentially harmful discontinuities in their receipt of services. Our study findings highlight the importance of continuing efforts to better monitor the use of psychotropic drugs with youth in state care. Future research should further explore potential disparities in receipt of mental health and substance abuse treatment services associated with sex and sexual orientation. Similarly, researchers and program managers should further explore the magnitude of and reasons for regional variation in service receipt.

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