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## An exploratory study on mental health service experience and its perceived impact on young adults transitioning out of foster care

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Sonia L. S. Aldape  
An Exploratory Study on  
Mental Health Service  
Experience and its  
Perceived Impact on  
Young Adults  
Transitioning Out  
Of Foster Care

### **ABSTRACT**

This qualitative study explores the self-reported perspectives of thirteen transitional aged (18-24 years old) current and former foster youth on their experiences with mental health services. This study fills a gap in mental health research that lacks substantial literature on the experiences of foster youth transitioning out of care, effectiveness of their mental health services and of foster youth's voices as consumers. This study aims to inform practice for clinicians and social workers referring or providing mental health services to current and or former foster youth. Clinicians and social workers can use their positions to provide and advocate for accessible and quality mental health treatment for this population and can support them to advocate for themselves when navigating mental health care. Self-reported decision-making process, service experience, opinions and motivations to seek treatment post-care are explored through qualitative interviews with thirteen adult participants in this study. The findings of this project reveal that participants' value autonomy, a caring relationship, feeling heard or understood and highlighted challenges to accessing mental health due to mental health stigma and mystification. Limitations and implications of the findings are discussed.

**AN EXPLORATORY STUDY ON MENTAL HEALTH SERVICE EXPERIENCE AND  
ITS PERCEIVED IMPACT ON YOUNG ADULTS TRANSITIONING OUT OF FOSTER  
CARE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2015

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I dedicate this thesis to my former foster brother, Andrew\*, who took his own life on January 2014 at the age of 25 and my late close friend and a former foster youth, Adela\*, who also took her own life at the age of 26 on March 2015, as I wrote this thesis. I hold immense appreciation for A Home Within's free mental health services for former foster youth and my own therapist who provided support during the difficult process of Masters thesis writing, field internship and grief. I remain dedicated to reducing suffering of youth and adults currently and formerly in foster care in honor of Andrew, Adela, my child self and the various others who have suffered throughout their experiences before, in and post foster care.

\*Names have been changed

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## CHAPTER I

### INTRODUCTION

In the last five years, headlines titled, “Drugging Our Kids” and “The Overmedication of Foster Children” have urged Americans to be alarmed and support efforts by advocates and researchers to reduce prescriptions for psychotropic medication for foster youth. Media outlets such as PBS, the Huffington Post, Al Jazeera America and NPR each aired segments or published articles beginning in the year 2011 making the American public aware of this troubling issue. The allocation of mental health services for foster youth appears to be a complex process. It is a system constructed by legal, economic, political, medical and social components influencing clients’ access, service provision and presumably, effectiveness.

This study was conducted in the geographic region of Central California. Consideration of the region’s relevant political history and demographic representation will be made throughout this project. The terms young adults formerly in foster care, transitional aged youth, former foster youth, emancipated young adults and young adults who aged out of foster care will be used interchangeably. Foster youth and youth in foster care will also be used interchangeably. The terms out of home care and foster care will be used interchangeably. Wellness, mental health treatment and healing will be used interchangeably, as well.

#### **Brief Recent Legal History of Mental Health Service in Foster Care**

A few years prior to the media attention, in 2002, a suit was filed against the California State Department of Social Services, the Department of Health Services and several agencies in Los Angeles County. The suit was filed in response to the neglect of the mental health needs of youth in foster care. Changes were approved in the year 2011 and now require the state to provide more “effective” mental health services for children in or about to enter foster care. Also



in 2011, in California, the policy AB989 was passed requiring each county to create a 3-year mental health plan for transition age youth (between ages 16 to 25 years old) in or formerly in foster care (California Youth Connection, 2014). These laws may have naturally increased the access and provision of mental health treatment for foster youth, although no studies have cited the correlation or calculated an increase. These laws did not include a plan to guide, oversee or regulate the mandated allotment of said, “effective” mental health treatment. This may leave concerned Americans with several questions: How are mental health utilization decisions being made, what is the rate of use, who is receiving treatment, what are youth experiencing when receiving mental health services, what treatments are they given and are they effective? To evaluate the current state and quality of mental health treatment for foster youth, it appears essential to study what effects result from these laws. This reinforces the need for more studies on mental health care in foster care.

Organizations in California like California Youth Connection (CYC), Young Minds Advocacy (YMAP) and Foster Youth Alliance (FYA) are policy change organizations that provide current and former foster youth resources and support to advocate for change in and post foster care. These organizations have worked on improving mental health services for youth in foster care. In 2011, they created and advocated for the bill, AB181 that ensures foster youth access to a mental health bill of rights document that is easy to understand. Additional to this mental health bill of rights, in 2015, a list of guidelines for prescribing psychiatric medications to foster youth was created. Currently, in 2015, CYC policy advocates are supporting the bill SB238 that is part of the psychotropic medication bill package to improve training, prescribing and oversight of psychotropic medication to foster youth (California Youth Connection, 2015).

These organizations are leading the current active policy responses and changes to the mental health service system in foster care.

### **Brief Summary of Current Mental Health Service Procedures in Foster Care**

At the present time, there is not a universal standard of mental health service procedures for youth in foster care. It varies from county to county. All foster youth in California have access to mental health services through Medi-Cal insurance coverage allotted upon approval by the county from the request of the youth, foster parent, child welfare worker or other adult in the youths' life. The availability of mental health providers and the county's successes in coordinating care varies and has not been measured (Gardner and Martyna, 2013). Gardner and Martyna (2013) describe some of the major issues with this unstandardized system as it fails, "roughly one in five people in California's foster care system who are transferred between counties after entering care," (p.1). The authors add,

Especially at risk are foster youth placed across county lines in California, who often experience lengthy delays or denials in accessing mental health services. The problem stems from California's county-based system of mental health delivery. Medi-Cal Specialty Mental Health Services are provided using a system of county-based managed care agencies or Mental Health Plans (MHPs) under contract with the Department of Health Care Services. Each MHP, in turn, contracts with local private mental health service providers (or uses county mental health staff) to deliver services. This system works efficiently for many children and youth. However, the county-based MHPs face substantial administrative barriers when services must be provided to young people placed out-of-county, outside the service area for its network of providers. These problems include difficulty:

- (1) finding providers and services in the child's county of residence ("host" county)
- (2) contracting for care
- (3) getting treatment authorizations
- (4) coordinating and monitoring care
- (5) securing adequate reimbursements from responsible parties including federal, state and local agencies (Gardner and Martyna, 2013, p. 1).

The YMAP report highlights one of the major and intricate issues of the current mental health service procedures. Youth in foster care face many impediments to accessing care, and the care itself is not always effective.

This study is qualitative and is exploratory in nature. This writer interviewed adults who are transition-aged and have been in foster care (not including kinship foster care) at least 3 years consecutively. The interview questions are guided by three themes to explore participants' mental health experience, current view of mental health service and future use of mental health service. Through these guiding questions, this researcher answers the research questions derived from the recent concerns made public by the media and California State/Los Angeles county lawsuit: How are mental health utilization decisions being made, what is the rate of use, what are youth experiencing when receiving mental health services, what treatments are they given and what are their effects?

## CHAPTER II

### LITERATURE REVIEW

#### Introduction

The review of the literature suggests the following statements: Child welfare researchers and advocates have tremendous concern for the mental health of current and former foster youth, youths' voices are lacking in the literature; and mental health clinicians need more research on the treatment experiences and outcomes for this population because existing research provides limited and mixed results. The literature reveals that the perspectives of foster youth are the perspectives of mental health consumers and can provide valuable insight into the effectiveness and accessibility of mental health that serves them. The central implication of the literature review speaks to the need for improving mental health referral, accessibility and practice. Additionally, this review informs the current study's purpose, hypothesis, methods and research questions. The lack of literature on the study's focus on transitional aged youth's perspectives on mental health care and the conflicting existing research findings supports the significant need for this study.

#### Mental Health Needs of Foster Youth

Reviewing the literature on this subject, Kerker and Dore (2006) conclude that the most recent studies from the late 1990s to 2005 reveal that the mental health needs of foster youth are not being met nationally due to barriers in the system. Their review highlights the high prevalence of mental health disorders and high risk factors in contrast to a low rate of mental health service use among youth transitioning out of foster care. One national study discussed in the review was by the National Survey of Child and Adolescent Well-Being (2003) which found that just 23% of children in foster care for 12 months had received at least one mental health service. Kerker and Dore also discuss several studies (Chernoff, Combs-Orme, Risley-Curtiss, &

Heisler, 1994; Clausen et al., 1998; Garland et al., 2000; Horwitz., Simms, & Farrington, 1994; Lawton and Rhea Chiles Center for Healthy Mothers and Babies, 2000; Pilowsky, 1995; Simms et al., 2000) that estimate up to 80% of children in foster care have significant mental health problems. These studies define, mental health service and mental health problems broadly. It is believed by researchers that this high rate of mental health needs and low rate of mental health service use leads to the higher rates of criminal justice involvement, homelessness, delinquency and teen pregnancy among foster youth compared to the general population. As a transitioning foster youth, the universally challenging developmental stage of young adulthood is much more difficult. The majority of foster children will experience trauma and some will have difficulty sustaining stable relationships as a consequence. Many have had seven or more placements, and will perhaps be abruptly discharged from foster care with little support or assistance and all in addition to having mental health challenges (Courtney and Heuring, 2005; Thomas, 2011; Garcia, et al, 2012; Michigan Department of Community Health, 2003). These studies suggest a possible negative correlation between high mental health needs and low mental health service use associated with negative outcomes when transitioning out of foster care. The limitations to these studies include the lack of foster youths' voices, a limited exploration by researchers and discussion of other possible influences on these. Foster youths' voices together with professional voices provide a multifaceted account of the mental health needs' of foster youth that are not reflected in these studies. Multifaceted perspectives are needed to provide a balanced view honoring anti-oppressive social work that values a client centered approach, placing the client as the expert. Anti-oppressive social work is described in the Theoretical Background Section of the Literature Review Chapter. Negative outcomes may have stronger correlations to other influences (such as placement changes, education disruptions, lack of consistent adults or years

spent in foster care) because youth experience several adverse circumstances within the foster care system.

### **Accessibility of Mental Health Services for Foster Youth**

Child welfare researchers and youth currently and formerly in foster care describe several barriers to foster youth receiving mental health services. The referral process for treatment is one of the areas highlighted as inaccessible. In Mclean's (2012) study of mental health services for youth in foster care, teachers, foster parents and child welfare workers reported several tensions in collaborative practice for supporting children in out of home care with extremely challenging behavior. In another study conducted in Washington State, caseworkers indicated having limited training in identifying mental health needs of youth in out of home care and working with mental health providers. On the other hand, mental health providers indicated challenges in working with state dependent youth, caseworkers and families, reporting that collaboration meetings would be helpful along with more training on the child welfare system including the unique needs of youth in foster care (Kerns et al., 2014). Studies such as Kerns et al. are unique in the literature and lack generalizability to other locations and States.

When foster youth transition out of foster care, they lose access to treatment and Medicaid coverage at age 21. One-half of youth in foster care at the age of 19 had no health insurance. The Dworsky and Courtney (2009) study reflect these concerns. The authors found steep declines in youths' use of psychotropic medication between the month before and the month after discharge from foster care. Outpatient treatment fell among the young people who were still in care at age 19. Two-thirds of young people who stopped taking psychotropic medication after leaving care had made that decision on their own without the advice of a health care professional while more than one-third of those who stopped taking psychotropic

medication while still in care had made that decision on their own without the advice of a health care professional. Researchers and advocates are concerned that mental health needs continue onto young adulthood while the added stress of emancipation, lack of support and discontinuing of treatment or access may worsen mental health. In a study focused on the voices of foster youth, participants (100%) reported not regularly visiting a health care provider and to have tried to “stay away” from health care providers because of financial constraints and inability to pay health bills also while all (100%) participants reported mental health conditions such as ADD, ADHD, depression, suicidal ideation, bipolar and anger management. None were being treated or managed by a health care provider at the time of the study. This study also found other roadblocks which foster youth described as being discharged from the child welfare system at age 18 but often being unaware of their Medicaid eligibility until age 21: “No one explained” “I didn’t realize it” “I thought it was for old people.” Other youth stated that they have had to prioritize needs stating that “of course you can’t focus...dealing with so much...insurance is not something you are thinking about...”(Krusczka et al., 2012). These perspectives of youth place into context how barriers to accessing mental health services including difficulties obtaining health insurance, finding a mental health provider, scheduling appointments and transportation can be overwhelming to the youth who has no support, distrusts adults and has to prioritize other needs due to challenging circumstances while transitioning out of care (Sakai et al., 2014). The rare voices of youth in the literature provide deeper insight into their experience of mental health use. The lack of a large variety of voices in the literature limits the findings generalizability and may have also affected reliability.

### **Effectiveness of Mental Health Services in Foster Care**

Although much of the literature reports that foster youth underutilize mental health services, a study of 423 adults between 18-21 years old who sought emergency shelter for the first time conducted by Thompsin and Hasin (2012), found those with histories of foster care were 70% more likely than those without such histories to report a psychiatric disorder. They were more than twice as likely to have received mental health counseling for a psychiatric disorder, to have been prescribed psychiatric medication and to have been hospitalized for psychiatric problems.

Various other studies conclude that mental health services are over utilized at alarming rates in the foster care system including the use of psychotropic medication (Bellamy et al., 2010; Longhofer et al., n.d.; dosReis et al., 2001; Villagrana, 2010). One of these studies estimates the rate of mental health utilization at about 5 times to 8 times greater than children who live in poverty. In spite of the over utilization of services, many studies have highlighted the lack of evidence that mental health services are effective for youth in foster care (Racusin et al., 2005; Bellamy et al., 2010). Several studies suggest that many children with substantial mental health difficulties who do not receive services, both inside and outside of foster care, often improve without treatment (Bellamy et al., 2010; Love et al., 2008) and even with treatment, behavioral and emotional challenges often persist into adulthood resulting in poor functional outcomes among former foster youth (Racusin et al., 2005; Love et al., 2008). In a fascinating study of 46 children at entry into foster care who were randomly assigned to an experimental group of mental health care and a controlled group of standard care, the groups showed no differences between depression, self esteem, behavior problems or placement stability. The Huyn-Feldt test revealed that the control group's depression improved over time, whereas the experimental groups did not (Love et al., 2008). There is significant amount of literature



indicating the ineffectiveness and overmedication of foster youth. These studies, however, did not consider other possible correlating factors or obstacles in their exploration of the recollection of youth formerly in and transitioning out of foster care. The voices of youth provides in depth insight into other correlating factors that may have influenced these findings.

The self reported experiences of foster youth who have received mental health treatment provide valuable insight into the perceived effectiveness of care. Unfortunately, few studies explore the perspectives of current and former foster youth. Youth's voices help to understand the quality of care they are receiving. It can provide the insight needed to improve satisfaction with care and protect youth from negative experiences during treatment (Lee et al., 2006). In Missouri, 389 17-year old foster youth were asked about their experiences with mental health providers. Thirty-seven percent of youth described a positive experience with a mental health professional attributing benefits of service and feeling a meaningful relationship with the clinician that was understanding and reliable. Negative experiences were mentioned by 26% of youth: "they drug you up," "it doesn't work," "they don't seem to do much," "she just couldn't help me," "they put words in your mouth," "I got into an argument with my counselor and was put back into foster care." Many youths stated they felt like the therapist was allied with the system or their guardian. They also reported unprofessional and unethical experiences that were demeaning as in the examples, "one therapist told me I was a black male and that I needed to be more masculine and not gay" and "my therapist would make me sit on her lap like I was a little kid when I was 13." Few youth mentioned positive experiences with medication; attitudes towards pharmaceutical interventions mirrored those of adult mental health service users. This study is unique and provides narrative data that is difficult to find. The small sample size limits generalizability and reliability of the study's data.

### **Current and Former Foster Youth' Perspectives**

Although few studies have collected the voices of transitioning foster youth; a few researchers have done so. Some studies (Singer et al., 2013; Salazar et al., 2011; Blakeslee, 2013) have explored the use of supports by former foster youth in transition. Singer et al. concluded that poor outcomes might occur not because of a lack of relational network members (such as family members, mentors or friends) but because foster youths' under-utilization of networks and the quality of the support network. The use of support networks can provide insight as to former foster youths' willingness to use mental health services after foster care. The study by Salazar et al. (2011) exemplifies these findings. Salazar et al. (2011) found that family (biological and foster) and friends are the most prevalent supports while informal supports and ties with formal service providers are not as strong. The researchers noted them as useful in providing more informational types of support. It is noteworthy for this study that formal service providers, which include mental health services, did not provide strong support for participants and are not primary sources of support sought by former foster youth. Future studies that explore the reasons behind the low use of formal support may provide insight to ways that formal support can be improved and increase accessibility.

The Mulkerns and Owen (2008) study provided deeper insight into the reasons that young adults may not seek formal support networks. Participants were a 13 youth sample who had emancipated at age 18, identified strongly with help-avoidance and self-sufficiency and reported inaccessible peer support. They reported often feeling alone and lacking a safety net. Emancipation solidified their beliefs in the value of avoiding help from others especially authoritative adults and relatedly the idea that seeking aid from others was incompatible with maintaining self-esteem. Due to the study's small sample size, the findings are not

generalizable. A larger sample size study could provide valuable and generalizable data that may inform advocates about the reasons that young adults may not seek formal support networks and the methods for improving accessibility and service provision.

These studies informed my research methodology and provide relevant data to inform my hypothesis. The studies were conducted with small sample sizes, limiting generalizability. Sociocultural and geographic influences were not clearly detailed in these studies also limiting their reliability. The findings of these studies reveal a need for further exploration on the executive processes behind young adults transitioning out of foster care's choices when utilizing support networks. These reasons may shed light into ineffective practices of formal service providers that policy change may improve. They support the need for additional studies including additional voices of transitioning foster youth and the need for further research on the perceived effectiveness and use of mental health services by foster youth.

### **Theoretical Background**

This study is informed by theories that influence this researcher's conceptualization of the themes in the Literature Review and Findings Chapters. Theoretical literature also defines concepts such as healing, alternatives to medication, effective mental health care and oppression that I use throughout this thesis. I utilize systems theory of trauma to conceptualize the mental health needs of foster youth. Using institutional oppression theory, I conceptualize the child welfare system, as an institution susceptible to being an oppressive structure for foster youth. Anti-oppressive clinical social work theory provides a set of values for social work research and practice. It also is a model of dynamic mental health treatment that does not recreate an oppressive and traumatic structure for foster youth while providing healing and empowerment using alternatives to medication.

*Systems Theory of Trauma*

Youth in foster care are placed in out of home care as a result of moderate to severe cases of physical abuse, emotional abuse, sexual abuse or neglect and many youth have survived dire poverty, food insecurity, environmental hazards, poor medical health among other grave challenges in childhood (Pinderhughes et al., 2007). Due to these conditions, inarguably, all youth in foster care suffer from the effects of trauma at some level impacting developmentally critical ages of childhood. Due to this ubiquitous trauma experience, current and former foster youth enter out of home care imperatively in need of avenues of healing.

Systems theory of trauma aids the understanding of the range of levels, complexity and opportunity that foster youth may experience from trauma as they reside within the foster care system. This theory originates from the first half of the 20<sup>th</sup> century by Ludwig von Bertalanffy when he conceived a view of the “world as chaos.” Simply defined, “systems theory sees all phenomena as related, so people are not seen as separate from their environment. Systems theory also sees trauma as much as a positive force as a negative one” (von Bertalanffy, 1968; Krippner and Laszlo, 1998). Systems theory helps to conceptualize the way youth who have endured trauma in foster care survive life threatening events and adverse environments. The theory allows us to understand that these youth have the opportunity to build new strengths and resiliency especially when placed in healthier environments. The theory avoids pathologizing foster youth by this reframing. The reframing of trauma using systems theory is impactful because, “the label of trauma victim seems to lead many people to take on the helplessness and damaged goods role implied by that label. There is some evidence that many types of victims, especially childhood abuse victims internalize a victim identity and are more likely to become victimized repeatedly in their lives” (Glenn, 2003; Tuckey, 2007).

*Institutional Oppression*

The child welfare system is as an institution susceptible to being an oppressive structure for foster youth. Snow (2006) makes a compelling case that foster care is oppressive:

Children in out-of-home care form an associative group that experiences the five criteria for oppression presented in Young's (1990) model. They are exploited as a commodity of the system and by virtue of their stigmatization. They are marginalized in institutional rule by diminished life chances and an exclusionary stigma. They are rendered powerless by the medico-judicial system that they enter as wards of the state. Their evolving capacity to assert their rights makes them powerless subject to the decisions of strangers. They are culturally dominated by the children's service disciplinary ideology and through their experience of instability and changes imposed on their life space. Youth in care are known to be at greater risk of victimization and violence by virtue of both their dependency state and care status. There is compelling evidence, then, to argue that children in care are uniquely oppressed (Snow, 2006, p. 98).

Using institutional oppression theory, I conceptualize the child welfare system as an institution susceptible to being an oppressive structure for foster youth. With awareness of both systems theory of trauma and institutional oppression, this study places mindful care into incorporating trauma-informed and anti-oppressive research methods through the formation of this project. Anti-oppressive methods will be defined in the following section.

*Anti-Oppressive Clinical Work*

Anti-oppressive practice is well described by Baines (2011). Baines (2011) states that there are ten themes that compose anti-oppressive practice in promoting social justice at the level of everyday frontline social work:

1. Macro and micro social relations generate oppression
2. Everyday experience is shaped by multiple oppressions
3. Social work is a contested and highly political practice
4. Social work is not a neutral caring profession, but an active political process
5. Social justice-oriented social work assists individuals while simultaneously seeking to transform society
6. Social work needs to build allies and work with social causes and movements
7. Social work's theoretical and practical development must be based on the struggles and needs of those who are oppressed and marginalized
8. Participatory approaches are necessary between practitioners and "clients"

9. Self-reflexive practice and ongoing social analysis are essential components of AOP
10. A blended heterodox social justice perspective provides the best potential for politicized, transformative social work practice (Baines, 2011, p. 4-7).

Informed by both Baines (2011) and Pollack (2004), this study was conceptualized and mindful of Anti-oppressive practice. Using the Anti-oppressive framework, this researcher was aware of the “issues of power and oppression within the provision of social work services themselves as well as within the lives of clients who have been marginalized and oppressed” (Pollack, 2004). The anti-oppressive framework of practice is a set of values used for this social work research. It also is a model of dynamic mental health treatment that does not recreate an oppressive and traumatic structure for foster youth while providing healing and empowerment opportunities using alternative modalities to medication. The ways that this study upholds anti-oppressive values is by informing and protecting participants’ rights and privacy; deindividualizing foster youths’ mental health needs and framing them in a wider social context; attempt to distance from the “expert” model by approaching the study as a qualitative exploratory project; recognizing that coping and resistance to oppression is a strength and not a pathology; committing to changing social relationships and institutions that perpetuate exclusion of marginalized groups of people by focusing on the ways this study may inform social work staff and clinicians to improve the institution; and locating the issue in the institution, not the individual.

## **Conclusion**

The controversies portrayed in the media coincide with the concerning data in the literature revealing foster youths’ urgent mental health needs, inconsistencies of mental health care treatment and a lack of evidence that mental health treatment is effective. The legal history and unstandardized mental health service procedures reveal an apparent complex system constructed by legal, economic, political, medical and social components, which influence

access, service provision and presumably, effectiveness. To conceptualize the various complexities that constitute the mental health service system within the foster care system, this study is informed by theoretical literature. Theories on trauma, institutional oppression and anti-oppressive practices influence the conceptualization of the themes in the literature review and findings chapters of this research project. The existing relevant literature has suggested a significant need for mental health services for foster youth, a significant lack of youth's voices in the literature, and a vital need for more research on the treatment experiences and outcomes. More research on the treatment experiences of and outcomes for foster youth as consumers could provide clarity on the limited and mixed results presented in the existing literature. Additionally, the current review informs this study's purpose, hypothesis, methods and research questions which is modeled on similar studies. This study aims to contribute new and updated data that builds upon the findings from the existing literature.

## CHAPTER III

### METHODOLOGY

#### **Research Purpose and Question**

The purpose of this study is to inform practice for clinicians and social workers that work with young adults transitioning out of or who were formerly in foster care. Being informed about a client's former mental health service experience and views of it, can guide practice in an effort to create quality mental health treatment services for this population. There are contradicting research studies on the use of mental health service by former foster youth. There are also few studies that include the voices of former foster youth exploring their experiences with and their perspectives on mental health services. The unfortunate lack of clarifying research and the lack of substantial perceived insight from youth's voices supports the need for this study. There are three over-arching exploratory research questions. The first is, what are the mental health service experiences of youth in foster care? The second is, as young adults transitioning out of or formerly in foster care, what are their current opinions of mental health services? Thirdly, would they seek mental health service in the future?

#### **Design**

This is a qualitative exploratory study. All participants have received the same treatment. Interviews were semi-structured. An interview guide (Appendix D: Interview Guide) was utilized but was used flexibly for some deviation as participants shared their experiences.

#### **Sample**

A convenience and snowball sampling was used. Recruitment began with a phone call to the agency to determine interest by the agency, feasibility and fit for the study. The agency director was provided a document agreeing to the HSR process and research (Appendix C: Agency Consent Form). The method of recruitment was through the agency's staff. According to



staff at the agency (from initial phone call), potential participants use the agency at varied times throughout a week and do not often take note of flyers. Considering this factor, the researcher provided consent forms to the agency's staff and requested referrals of participants by them (Appendix B: Informed Consent Form). Agency staff asked a potential participant that met eligibility (staff already had this personal information) if they are interested in participating in the study. When they indicated interest, a consent form was given to sign and a preferred phone number was collected that same day. The agency was only provided with 15 consent forms to indicate when 15 potential participants had been recruited. Upon collecting at least 12 signed consent forms from interested participants, the researcher picked up the consent forms and gave each potential participant a call by phone to provide further detail about the study.

Participants are between the ages of 18 and 21 of varying race, ethnicity, gender (including all other identity markers). Participants have at least 3 consecutive years of placement experience in foster care including only residential settings or foster family homes (excluding kinship homes) to focus on youth who have had spent a significant length of time in foster care. Participants live or work in Central California and were recruited from a community agency serving transition aged current and former foster youth. The community agency assists current and former foster youth transitioning to adulthood self sufficiently through a formal case management system with co-located staff from the county's Probation and Mental Health departments, Independent Living Program, Community College and High School District. The geographic choice stems from the researcher's personal interest in conducting research in her hometown where she may work with current or former foster youth in the future. This study gathered the retrospective experiences and current views of young adults transitioning or formerly in foster care therefore only included adult participants between 18-21 years old.

## **Ethics and Safeguards**

All research materials including recordings, transcriptions, analyses and consent/assent documents have been stored in a secure location and will be stored for three years, according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data is password protected during the storage period. Consent letters are kept separate from notes and transcripts, and each participant is assigned a code number, which is placed on all materials. Audio recording digital files does not include names in recorded content. It is possible that individuals may have experienced stress speaking about their past. However, participants were not be pushed to discuss experiences they did not want to discuss and they were able to skip any question they chose. The interviewer is a clinician in training and was aware of signs of discomfort or distress and monitored interviews to avoid participant distress. All participants were informed at the beginning of the interview that they could decline to answer any question, or end the interview for any reason. Each participant had access to a resource form to acquire additional support after the interview, if it was needed (Appendix F: Referral Sources for Participants). Copies of the resource form were stationed at the community agency where they were recruited for participants to pick up while signing the consent form and any time after the interview until March 1, 2015. The content in the resource form was also offered through the phone during the interview. The agency, from which they were recruited, also provides support from staff and referrals to supportive organizations. This increased accessibility to support for participants if the interview became distressing. Clients were able to withdraw from the study at any time until March 1, 2015.

**Data Collection**

Data collection occurred using the researcher's phone. Participants were audio recorded with a Samsung Galaxy Note 3 phone through a secondary phone number provided by the phone application, Google Voice. The audio recording was conducted by the phone application, Call Recorder. The researcher also took hand written notes. The phone interviews were conducted in a quiet private space in the researcher's home and the researcher recommended that the participant do the same.

**Revisions of Methodology**

The human subjects review committee approved two revisions to this study's initial methodology during the recruiting stage of this research project (Appendix E: HSR Amendment Approval Letter). The changes made are of the participant's age range from 18 to 21 to the expanded ages of 18 to 24 years old. The request was made to represent the full age definition of transition-aged youth and to increase inclusivity of potential participants who were consumers of the agency, whom this study recruited participants from. The second change discarded the use of phone interviews and instead conducted the interviews in person in a private room at the agency's location, whom this study recruited participants from. The in person interviews were recorded by the researcher's personal computer using Microsoft Office Software. The change was due to several potential participants reporting the lack of access to a reliable phone to participate in phone interviews.

**CHAPTER IV**

**FINDINGS**

The purpose of this research project is to explore the mental health experiences of transitional aged current and former foster youth, their opinions and willingness to seek mental health services in the future. This chapter outlines the findings of this exploratory, qualitative study based on 13 interviews with current and former foster youth who were transition aged and had at least 3 years experience in foster home or group home care.

The data presented in this chapter was collected through in person interviews, which were transcribed and analyzed in an open coding format. “Open coding is a process of labeling concepts, defining and developing categories based on their properties and dimensions. It is used to analyze qualitative data” (Khandkar, n.d, p.1). The process of open coding to analyze the data collected and formulate codes in this study is illustrated in Figure 1. Open coding is a tool of grounded theory, which is a method of using empirical data without preconceived theories. Figure 2 illustrates how grounded theory was used in the development of codes for this study.

Figure 1. Qualitative Data Analysis (Khandkar, n.d., p.1)

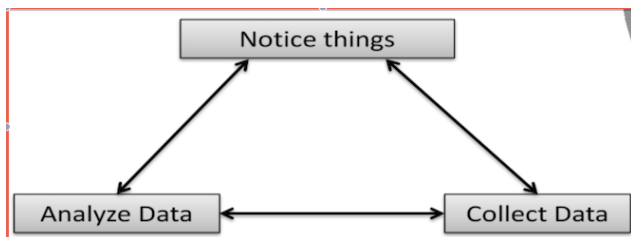
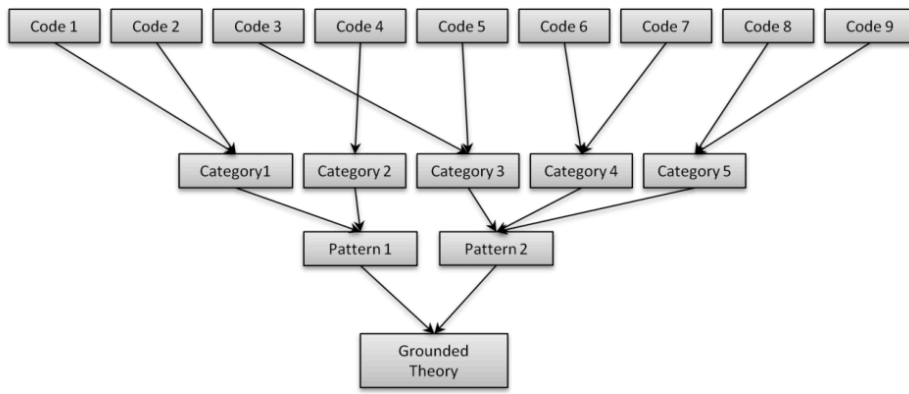


Figure 2. Grounded Theory Methodology (Khandkar,n.d., p. 5)



The interview was centered on three broad areas of inquiry, with several questions for each area. The areas of inquiry are: 1) Current and former foster youths’ experience of receiving mental health services; 2) The opinions of mental health services as helpful (from their own experiences and in general); and 3) Their willingness to seek mental health services in the present or future. Demographic data was also collected during the interviews.

Five main themes emerged from the data during analysis, each theme encompassing several secondary themes. This section will explain and describe the five main themes and their respective secondary themes using examples from the interviews in the interest of maintaining the participant’s voices. The five main themes this section describes are: 1) The value of autonomy; 2) The value of caring relationships; 3) The desire to be heard or understood; 4) Mental health stigma and; 5) Mental health service mystification. This study generated some questions that were not related to the research question about the impact of mental health policies in the foster care system, the effectiveness of mental health services for foster youth and about racial and ethnic considerations in the mental health experience and perspectives of current and former foster youth. These questions will be explored in the Discussion chapter. This chapter begins with an explanation of the demographic findings.

**Demographic Data**

A total of thirteen individuals participated in in-person interviews and answered all demographic questions. All study participants were purposefully recruited with a history of at least three years in foster care, a status of currently in care or emancipated and all were transition aged (18 to 24 years old).

Table 1. Demographic Data

<b>DEMOGRAPHIC DATA</b>	<b>(n)</b>	<b>(%)</b>	<b>Mean or Mode</b>	<b>Total</b>
<b>Age</b>	18	.15	20.4	2
	21	.31		4
	19	.08		1
	20	.31		4
	22	.08		1
	24	.08		1
<b>Gender</b>	Female	.48	Male (mode)	5
	Male	.62		8
<b>Race</b>	AfricanAmerican	.14	Caucasian (mode)	2
	Caucasian	.42		6
	Asian	0		0
	Hispanic/Latino	.36		5
	NativeAmerican	.07		1
<b>Years in Foster Care</b>	n ≤ 5	.23	10.1	3
	5 < n > 10	.14		2
	n ≥ 10	.62		8
<b>Current Placement</b>	Homeless	.07	Foster Home (mode)	1
	Own Apartment	.14		2
	With Biological Family	.14		2
	Group Home	.07		1
	Transitional			
	Supportive Housing	.23		3
	Foster Home	.36		5

Forty-two percent (n=6) of participants self identified as Caucasian. Thirty-six percent (n=5) self identified as Hispanic, while fourteen percent as African American and seven percent as Native American. Sixty-two percent of participants self-identified as male and forty-eight percent self-identified as female. The average years spent in foster care was 10.1. In comparison to national averages, the Hispanic representation was higher and the average number of years spent in foster care was much higher than the average of two years (ACYF, 2013). Racial

demographics were closely representative of the most recent demographic data of Central California (United States Census Bureau, 2015).

Participants were also asked about their current status and living situation. The percentage of participants in extended foster care through the recent AB12 law was sixty-two percent and the percentage of emancipated participants was forty-eight. Seven percent (n=1) of participants reported their housing situation as homeless. Seven percent also reported living in a group home. Fifteen percent of participants reported living on their own. Fifteen percent also reported living with biological family. Twenty-three percent of participants reported living in transitional housing. Thirty-eight percent reported living in extended foster home care. Since the implementation of the AB12 law extending foster care to the age of 21 in 2010 in California, statistical data of youth demographics including extended care has not been published.

In regards to exploratory data gathered about mental health experience several close-ended questions were asked. Ninety-two percent of participants had received mental health services while in foster care while seven percent did not. Thirty percent of participants were receiving mental health services at the time of interview. Thirty eight percent received medication as a mental health service. The average years participants received mental health services was 5.7 and the average number of clinicians' participants had throughout their experience was 3.1. Fourteen percent of participants reported having over five therapists throughout their experience. Implications and questions regarding these findings will be discussed in the following chapter.

The following sections outline the four main themes and their respective subthemes that emerged during qualitative data analysis. In the following sections excerpts are listed without names to protect participant confidentiality.

## **The Value of Autonomy**

Only three participants reported that they were included in the decision to receive mental health services. Each of these participants were observed as displaying pride, empowerment and autonomy in being involved in the decision. Every one of the ten participants that reported that they were not included or their opinion was not honored reflected on negative feelings about the decision. The three main subheadings I will discuss in this section are: having a choice as empowering, mandated services as oppressive, resistance through noncompliance.

### *Mandated Service as Oppressive*

Most participants in this study did not take part in the decision to receive mental health services. These participants reflected on negative feelings and reported the desire to have been involved in the decision of receiving mental health service. Negative feelings were described in the form of being forced and the denial of rights. The following are some excerpts from the interviews,

They didn't let me put my opinion on it, just forced. If I had helped with the decision, I would have gone but I didn't like they didn't let me speak.

Social workers do it without consulting youth. It was not good because I wasn't involved in the decision. At any age you should be asked, unless you can't talk, but at 10 years old you are old enough to speak for yourself.

I felt like I was being forced to do things I didn't want to do. Everybody had to do it.

I felt like I didn't want to or need to. I guess I didn't have a choice.

These participants mostly described negative feelings due to being forced and not consulted in the decision making process. The excerpts above illustrate the varying ways that current and former foster youth reflected on negative reactions to how that decision was made for them and not by them.



*Having a Choice as Empowering*

The few participants (n= 3) that had been consulted or made their own choice did not report negative feelings. The tone and language in which most of these participants described the process and feeling was observed with pride, assertiveness and confidence. The following are excerpts from these participants:

I didn't want it. The social workers wanted me to have mental health services and I said no and she didn't try again... It felt good she listened I guess. It was whatever.

I made the decision. I felt better and I did it because I wanted the services.

I wanted to be in therapy. I was trying to be my healthiest in my mind. I knew in school that the brain functioned and I really wanted to have a healthy mind.

I'm in counseling now because it was recommended to me. I made the decision myself though. Im happy with it

These participants when asked how they felt about making their own decision included a positive emotion such as "good," "better," and "happy." Their tone when reporting these feelings appeared assertive and confident as they spoke using direct eye contact and a focused, prideful facial expression.

*Resistance by Noncompliance*

For several participants (n= 10) who were not included in the decision process to receive mental health services, they did not want to participate and did not engage in treatment. There were four participant reports of noncompliance with the service. The following excerpts narrate these descriptions:

I was forced and it was not a good fit. I never tried to connect. I didn't want to be there.

Something I didn't like would be talking to somebody about my feelings or what I did that week. So I was mostly quiet. I don't know if it helped.

Yes, I had one therapist and medication but I don't take it. For the last 4 years I been on it and I don't always take it because I don't want it.

These young adults described their reactions to being forced into mental health services responding with resistance by not complying with the service. They used words such as “I never tried to connect,” “I was mostly quiet,” “I don't take it (medication).” The statements are powerful descriptions of the negative feelings that several youth felt about mandated treatment and what they perceived to be the cause of their disengagement.

### **The Value of A Caring Relationship**

Among the several participants (n= 7) who described a positive experience with their mental health services there was a key emphasis on how much the participant felt the clinician cared about her. Seven out of thirteen participants believed counseling was helpful for them and eight participants out of ten were able to describe a quality they liked about their service. The following are some excerpts that described their value of a caring relationship from their positive experiences.

I liked that I didn't have to go through things alone.

The psychiatrist was cool. He listened to me.

I was thankful someone was coming to see me.

I liked that I formed a good relationship with the mental health worker.

I liked I could communicate with a person.

All my therapists were pretty good. They have patience with everybody.

I had lasting friendships with some people who were working with me who were able to mentor me and mold me to the person I am today.

When asked what would help improve a clinician's service to current and former foster youth, emphasis on a caring relationship was described. The following are some examples:

Be there for you to try to help you get through your problems.

Just be patient.

I would suggest to them to not try to threaten or argue with you.

Keep it up. They are there for you.

Be ready to help them and not be judgmental.

Most participants described having a caring relationship or improving how a clinician does create a caring relationship as an important part of the service. They emphasized patience, not arguing or threatening, being present, not being judgmental, and being supportive. It was important for the youth to have the opportunity to communicate, be listened to and connect with the clinician. For the youth, these are elements of a caring relationship.

### **The Value of Feeling Heard or Understood**

All participants who described a negative experience with mental health services, reported feeling that they were not heard or understood by their clinician or the people who made the decision for them to obtain mental health services. The following excerpts are examples:

It seemed like they just put me on meds to keep me quiet so that I couldn't complain about anything. If people would have listened to what I was saying when I was younger, I would have been better.

I think the mental health people thought everything was going to be okay because it was not happening to them.

One participant, who felt she was heard and understood, highlighted this as an attribute to her positive experience with receiving mental health services. The empowered confidence was observed in her tone through the following excerpt,

I know what I like now and can describe those traits

When asked what would help improve a clinician's service to current and former foster youth, being heard or understood was emphasized and described with more frequency and importance than elements of a caring relationship. The following are some examples:

If they want to see more progress in the future they have to understand that not all pain is alike and that not all the cases are the same.

Different foster youth have different problems so I would suggest not to jump into things at first and know more about their backgrounds and environment they came from. Like where they living before and conditions.

I think that they should know its hard to be in foster care and live with strangers, be more compassionate.

Don't feel like you seem to be superior. Listen and understand the person's perspective before you pass judgment.

The questions don't have to get too personal and for them to listen to what the patient has to say or wants to say at the time.

Just listen, honestly, because if you listen to what they are saying. That would speak more volume than can ever be taught or talked into. Once you understand their issues you can understand where they are coming from and where their frustrations are.

Among all participants but one who reported positive experiences receiving mental health services, a caring relationship was perceived as a key factor. Among most participants who reported negative experiences, it was due to a lack of being listened to or understood in the decision making process or the service itself. When asked about how services can be improved by clinicians, almost all participants described the value of feeling of being heard and understood above the feeling of being cared for by their clinician. During the recruitment process, it was notable that all invited potential participants consented and completed the interview displaying a strong interest from the selected population to be heard and share their perspectives.

### **Mental Health Stigma**

Seven out of thirteen participants (53%) described mental health care services negatively. When asked specifically about their views on medication, nine participants had a negative response. Many of the perspectives associated mental health services with several negative stereotypes. These sort of beliefs are below:

I didn't feel like anybody telling me what's wrong with me when I already know.

Its like someone who is trying to tell you that you have an illness and make you feel like you are bipolar or angry. I don't get angry. I'm just like whatever.

Mental health services are people that are only there to make a report based on what is wrong with you not on circumstance.

I don't really care for medication even when I am sick. I don't like medication unless I really have to use it.

I think of a psych ward or a psycho killer... Yeah, I guess it helped, Im not a psycho.

Someone somewhere becomes crazy and someone wants to dig into my mind to figure out why.

I would never take medication, its addictive. I would recommend the gym.

Mental health stigma was common among participants even those that had named a positive experience receiving mental health services. Stigma was also observed in every participant who did not want to receive mental health services. Eight participants reported that they would seek mental health services in the future while five reported that they would not. Those that reported they would not described reasons that were viewed, as stigma, as quoted above.

### **Mental Health Mystification**

Similar to stigma of mental health, mystification of the services received was observed. The term mystification refers to the sociological definition of the process of masking or covering

up central aspects of society in which forms social domination or camouflages social structures of the state which assists in its reproduction and seen as legitimate (Turner, 2012). In this case, mystification is the process of the mental health system holding power over its' patients by making its information and service education inaccessible through the means of uncommon professional language, treatment descriptions and types unavailable to the patient, indefinable quality care. Throughout almost every participant's interview, the uncertainty about their services effectiveness, lack of awareness of medications taken and a lack of mental health knowledge was pervasive. "I don't know" was a common answer that was used during direct questions about the types of mental health services used, the types of clinicians seen or its effectiveness. The following are examples:

Yeah, I took medication. Not sure what it was.

I don't think it necessarily helped, it was like routine but it was not all bad though.

I don't know what I was taking. For depression I think.

[Medication] I think there is other ways to go about it but that they do that cuz it's the easiest. I don't know what else they could do.

No. I don't know personally I don't think I need help. I would do something active at least. Not just sit around and be all sad and stuff.

Medication could be helpful though I don't believe in it, because I know somebody who uses it and it can be helpful but I don't know. I wouldn't take it.

I don't know, I guess it helped but I don't know how.

Helpful? In some cases yeah cuz its like for those schizophrenic people who get medicine and if they are off it they are psycho again.

Not sure how it helped but I know it was nice to have a friend to talk to.

It did, anger is the same though, the therapists question made things worse at the end because they were too personal questions.

It was not needed for me, depends on the person. I used to take meds I don't know why and once I turned 18 stopped and I'm doing fine myself.

Participants had difficulty recollecting the medication they had received, describing how the service was effective and providing reasoning when follow up questions were asked. From the five participants who had received medication, only one was able to report the name of the medication taken. The four others stated they did not know. Very few participants were able to name a specific way or express confidence that their service was effective or helped them improve in any way although most (n=10) participants expressed that they believe mental health services can be helpful in general and seven out of twelve (58%) who received services believed it was helpful to them.

### **Summary**

The main themes that emerged from the qualitative interviews in this study exploring the experience and perspectives of current and former foster youth of transitional age are *the value of autonomy, the value of caring relationships, stigma and mystification of mental health care*. These themes and the supporting excerpts suggest that current and former foster youth may potentially experience an overutilization of service, ineffective service, and an alarming amount of perceived negative experiences and opinions of receiving mental health care. These themes may suggest ways that transitional aged foster youth access and seek mental health care in the future. The themes highly suggest that there are various ways in which services can be improved to improve experience, perceptions, increase effectiveness and accessibility of mental health services for current and former foster youth. The implications of these findings for clinicians, social work and child welfare agencies follow in the next chapter. The following chapter also contains a further discussion of the four themes and addresses possible limitations and study bias.

## CHAPTER V

### DISCUSSION

This study explored the experiences and perspectives of transition-aged youth currently or formerly in foster care in Central California. The objective of this study was to explore thirteen young adult's self-reported experiences and opinions on mental health services. There have been contradictory findings about this topic in past research. In this qualitative exploratory study, participants were given the opportunity to share their responses in great detail. This chapter investigates findings that resulted from their responses, with more in-depth discussion of results outlined briefly in the Findings chapter. In addition, limitations of the study, considerations for practice, policy and areas for further research will be included.

#### **Summary of Findings**

The major findings of this research project are that most transition aged current and former foster youth who participated in this project, have used mental health services and have opinions of mental health services based on a high value in the quality of the relationship, societal influences of stigma and the experience of mystification. These main findings are generally supported in the literature, however, the literature revealed contradictory data and there are gaps in the literature that have not explored this topic directly. The findings support literature that also found that most youth in foster care utilize mental health services, have little or no involvement in the decision to receive mental health services and have had little or no programs to combat stigma and mystification of mental health need and service use. The following section highlights how the four themes from this study compare with the existing literature on the connection between mental health service experience and the perceptions of mental health services including the self reported willingness to seek care.



## **Interpretation of Findings**

### *The Value of Autonomy*

A key finding of this research project is participants stress on the importance of feeling a sense of power or influence over decisions about one's own mental health service use. All but one participant had received mental health services. Out of those who received services, only three participants (25%) took part in the decision. All nine participants (69%) who did not take part in the decision to receive services expressed negative feelings about not having had a voice in the decision making process. There seemed to be a correlation between the findings of seven participants who believed the decision to receive mental health services was made appropriately for their case with the finding of seven participants who also found their mental health services helpful. Negative feelings were expressed in varying intensity. Negative feelings were described as oppressive, forced, and inadequate. While, having been consulted was described as empowering.

In the literature, there exists an important gap that explores the decision making process of allocating mental health services to foster youth. Most of the literature on mental health service allocation of foster youth centers on over and under utilization of service use and help seeking behaviors. There are however, throughout the media, conversations and debates around a foster youth's mental health rights and the age of consent. As it stands, in California, minors 12 years old or older may consent for outpatient mental health treatment and counseling (Gudeman, 2008). This finding raises questions about the accessibility of mental health laws and rights for foster youth.

### *The Value of a Caring Relationship*

The fact that current and former foster youth highly value the caring element of a therapeutic relationship is supported in the literature (Lee et al., 2006; Salazar et al., 2011; Dworsky and Courtney, 2009). In this research study, all participants who received mental health services and described any positive experience of the service, described elements of a caring relationship (seven of the thirteen participants).

In the study by Lee et al., (2006) in the state of Missouri, 17-year-old foster youth were asked about their experience with mental health providers. In that study, youth describing positive experiences also universally recollected the value of the caring relationship and those that described a negative experience universally recollected how the therapeutic relationship failed to be caring. Most of these participants described the feeling that their clinician was allied with the system or their guardian instead of caring for them. In a related study by Salazar et al. (2011), it was found that most former foster youth most prevalently utilized family and friends as supports instead of service providers. The degree of closeness to former foster youth is highly valued for seeking support and likely correlated to a higher sense of being cared for.

#### *The Value of Being Heard or Understood*

All participants who received mental health services and described a positive experience with the service, described the value of being heard or understood. Those who described a positive experience consisted of seven of the thirteen (54%) participants. This finding is supported by some literature that reported similar findings (Lee et al., 2006; Mulkerns and Owen, 2008; Dworsky and Courtney, 2009). Within both the decision making process and the actual treatment, participants described the value of their opinions being heard and their perspectives being understood.

Similarly, in a study by Lee et al. (2006) which reported similar findings, youth described negative experiences recollecting moments when they felt they were not heard or understood such as in the following statements,

They put words in your mouth.

I got into an argument with my counselor.

One therapist told me I was a black male and that I needed to be more masculine and not gay.

This research demonstrates that youth do not trust that providers will hear and understand them. This is likely due to past experiences in which this was true. In the Mulkerns and Owen (2008) study, they concluded that emancipation solidified former foster youth's beliefs in the value of avoiding help from others especially authoritative adults. Also, in the Dworsky and Courtney (2009) study, it was found that two-third of young people post-foster care that stopped taking psychotropic medication made the decision themselves without the advice of a health care professional. Participants highly value being heard or understood and may assume that health care professionals or adults may be authoritative and not hear or understand them because this positive relational element may have been rare in their experiences with adults in foster care. Or a negative relational experience with adults in which they were not heard or understood may have impacted them and their expectations of adults. Further study of these sorts of experiences is suggested.

### *Mental Health Stigma*

Mental health stigma is widely seen throughout society. It was highly present in this research project's findings as well. Participants described their perspectives of mental health services in a variety of ways demonstrating a stigma towards mental health services for instance stating they are a service for "crazy people," and a service for severe mental illness such as

psychosis. Participants also described several stereotypes such as, “they will only drug you up.” Seven out of thirteen participants (54%) described a stigmatized perspective of mental health services. The literature lacks direct study of stigma among foster youth. What is present in the related literature is significant data on the high use of mental health services and mental health service need among foster youth.

Several studies from the National Survey of Child and Adolescent Well-Being (2013) review (Chernoff et al., 1994; Clausen et al., 1998; Garland et al., 2000; Horwitz., Simms, & Farrington, 1994; Lawton and Rhea Chiles Center for Healthy Mothers and Babies, 2000; Pilowsky, 1995; Simms et al., 2000), estimate up to 80% of children in foster care have significant mental health needs. These studies define mental health need broadly. Studies (Courtney, 2005; Thomas, 2011; Garcia, et al, 2012; Michigan Department of Community Health, 2003) describe these needs due to foster youth experiencing trauma, seven or more placements, the lack of stable relationships, and abrupt discharge from foster care with little support or assistance during a universally difficult developmental stage. The literature demonstrates that mental health need and service use is significant among foster youth but this research study reveals that the access to education about mental health need and use is lacking.

In a study from Washington State, Kerns et al. (2014), describes one possible reason. The study interviewed caseworkers and mental health providers working in the foster care system. Caseworkers indicated having limited training in identifying mental health needs of youth and working with mental health providers. Mental health providers also indicated challenges with working with state dependent youth, caseworkers and their families. Participants of the study requested the need for collaboration and additional training. There is no known standard practice of mental health assessment, service allocation, education or programs to combat stigma in the

foster care system. This study demonstrates a need for combatting stigma of mental health care in the foster care community.

### *Mental Health Service Mystification*

Very similarly to the prevalence of stigma, mental health service mystification, the state of inaccessibility of the mental health system's practices, education and language for consumers, was also common among participant's responses. Out of five participants who took psychotropic medication (38%), four did not know the name or type of medication they were given. Participants described an average of 5.7 years of therapy and an average of 3 clinicians throughout their mental health service use experience. Two participants described having more than 3 therapists. These are high number of clinicians and years of therapy. A high number of participants (46%) could not describe any way that their therapy was helpful. A common response to direct questions about the types of mental health services used, the types of clinicians seen or its effectiveness was "I don't know."

Like the previous section on stigma, the literature review does not directly describe mystification of mental health service among foster youth. It describes the high amount of evidence that foster youth have a high need and use of mental health services supporting the implication stated in the previous section on Stigma in the Discussion chapter that access to education, laws and rights about mental health need, and mental health use is needed. Further studies on the topic of mystification are suggested.

### **Limitations and Researcher Bias**

The study design was successful in collecting the target population's experience and perceptions about their mental health service use, opinions and self reported motivation to seek services in the future. This study remained close to the participant's voices, an important part of

the study design, and emphasizes the meaning that participants made of their experiences. The study's demographics reflected a sample of diversity from the region's general population.

The interview guide prompted responses that were tied to the research question, however the interview guide appeared to greatly impact the themes generated from the data analysis. The interview guide contained specific questions about their positive and negative experiences as well as positive and negative opinions of mental health service and experience.

The major limitations of this study come through researcher bias, sample bias, including a small sample size and self-selection bias. There are a number of sample biases in this study, which can indicate problems with validity and reliability. As a former foster youth, I hold values, shared experiences and strong opinions that may have influenced my choice of research questions, tone during this study's interviews, the analysis of this study and of the topics covered in the Discussion chapter. My research topic, location and study questions were chosen due to this subjectivity. Consideration and thoughtfulness was placed in my self-awareness and intention of objectivity throughout the interview and analysis.

All study participants self-selected for the interviews, which may indicate increased self-reflection on the part of participants and may be more likely to have strong opinions about and experiences with receiving mental health services. The study was intentionally regionally specific with all participants living in the same town in Central California.

### **Considerations for Practice, Policy and Future Research**

This study contributes to the literature by documenting how current and former transition aged foster youth have experienced and perceive mental health services, by describing themes that identify how relationships, personal values and societal influences can impact how they engage with mental health services. The study's findings emphasized the importance of

autonomy, quality and thoughtful relationships and access to mental health rights, laws and education.

Clinicians and child welfare staff can promote the positive aspects of mental health service allocation by engaging youth in the decision making process, creating quality and thoughtful relationships and making mental health rights and education accessible to current and former foster youth. Clinicians and child welfare staff can also normalize the experience of having mental health needs and the experience of seeking mental health services to combat stigma. Clinicians and child welfare staff can also advocate (and teach youth to advocate) influencing mental health and child welfare policy that can improve the quality and accessibility of mental health service to foster youth.

Future research would be beneficial looking at ways that the decision is made to obtain mental health services for foster youth. It would also be beneficial to look at how accessible mental health services are for current and former foster youth. Thirdly, it would also be beneficial to collect more perspectives of current and former foster youth in regards to their mental health education, rights, laws, effectiveness of mental health services and mental health policies.

## **Conclusion**

Current and former foster youth are overwhelmingly at risk for trauma, depression, anxiety and other mental health conditions due to their experiences of difficult transitions, several placements and experience of neglect or abuse during universally challenging developmental stages. Because it is prevalent in this population to need and use mental health services, it is important both for clinicians and child welfare staff to be aware of how youth

experience mental health services, their perceptions and self-reported willingness to seek mental health care in the future.

This study provides important information about how current and former foster youth experience and perceive mental health services. The findings and discussion reported here are meant to maintain the participants' voices and at the same time draw connections from their voices.

This study is limited by a small sample, researcher bias, self-selection sample bias and self-reported bias. Self-selection and self-reports are privy to responses that serve the participant's interests. This researcher also may have been influenced by bias. Further research should continue to probe the research question. Though this study is not generalizable, this research deepens our understanding of how current and former foster youth can be negatively affected by mental health service use and how clinicians, caregivers and foster care staff can foster positive experiences, what can impact the negative perceptions and unwillingness to seek mental health care in the future and the ways mental health services have felt effective as well as how obstacles may be alleviated. It is my hope that the information presented in this study will be of use to researchers, clinicians, caregivers, policy makers and child welfare staff by expanding research on the topic, improving the mental health service decision-making process, quality of treatment, accessibility of education about mental health and mental health policies for current and former foster youth.



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**Appendix A: HSR Approval Letter**



**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

January 13, 2015

Sonia Aldape

Dear Sonia,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

**Appendix B: Informed Consent Form  
Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA**

.....

**Title of Study:** An Exploratory Study on Mental Health Service Experience and its Perceived Impact on Young Adults Transitioning Out of Foster Care

**Investigator(s):** Sonia L. S. Aldape, MSW Candidate

.....

**Introduction**

- You are being asked to be in a research study exploring your experiences and perspectives about seeking mental health services.
- You were selected as a possible participant because you have been identified by the [retracted] as being potentially interested in talking about your experiences with the mental health system and are between the ages of 18-21 years old and have been in foster care for at least 3 consecutive years.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

- The purpose of the study is to provide future social workers and therapists with knowledge about the types of experiences that youth in foster care have when receiving mental health services to discover if these services need to be improved. Another purpose of this study is to see if mental health services are effective and if young adults formerly in foster care's experiences have affected whether or not they would seek these services out in the future.
- This study is being conducted as a research requirement for my Master's in Social Work degree.

- Ultimately, this research may be published or presented at professional conferences.

### **Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things: Read and sign this consent form and participate in a 1-hour phone interview that will ask demographic questions such as age, gender and ethnicity and questions to explore your experience with mental health services while in foster care and your current opinions of seeking mental health services in the future.

### **Risks/Discomforts of Being in this Study**

- The study has the following risks. First, it is possible that you may experience discomfort when speaking about past experiences with mental health services. You will not be pushed to discuss experiences or details you do not want to. You have the right to decline answering a question or end the interview for any reason and at any time. After completing the interview, I can remove your data up until March 1, 2015 after the interview. **In the case that you need extra support, due to your participation in this study, I have attached a list of local resources to your copy of the Informed Consent form.**

### **Benefits of Being in the Study**

- The benefits of participation are having an opportunity to talk about your experiences with and opinions of mental health services.
- The benefits to social work involve informing social workers and therapists about the perceived effectiveness of mental health services on young adults formerly in foster care, hopefully leading to better services in the future.

### **Confidentiality**

- Your participation will be kept confidential. You will be recorded throughout the interview but your name or contact information will not be asked during the recording. Your recorded interview will not be linked to your name or contact information. It will be stored securely with a date and a code number for reference. The [retracted] staff who referred you to this study will be the only ones to know about your potential participation but not if you chose to participate. **I will not provide [retracted] staff with any specific information that you give me and I will not speak to any staff about what you say.** In addition, the records of this study will be kept strictly confidential. The audio recording will be deleted from the recording device as soon as I complete their transcription. I will be the only one transcribing your interviews.
- All research materials including recordings, transcriptions, analyses and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any identifying information in any presentation we make or report we may publish that would make it possible to identify you or if needed, we will disguise it.

**Payments/gift**

- You will not receive any compensation or financial payment for your participation.

**Right to Refuse or Withdraw**

- The decision to participate in this study is entirely voluntary. You may refuse to take part in the study at *any time* before, during and after the interview without affecting your relationship with the researchers of this study or Smith College or the [retracted]. Your

decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1, 2015. After that date, your information will be part of the thesis or future presentation.

**Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sonia at [retracted] or by telephone at [retracted]. If you would like a summary of the study results, one will be available at the [retracted]. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- **Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.**

.....

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....

**1. I agree to be audio taped for this interview:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

**2. I agree to be interviewed, but I do not want the interview to be taped:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

Appendix C: Agency Consent Form



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

[Date]

Smith College  
School for Social Work  
Lilly Hall  
Northampton, MA 01063  
To Whom It May Concern,

\_\_\_\_\_ (agency) gives permission for Sonia L. S. Aldape (Master's student researcher) to locate her research in this agency,

\_\_\_\_\_ (agency). We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) performs a review of the research proposed by Sonia L. S. Aldape (Master's student researcher). \_\_\_\_\_ (agency) will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,

\_\_\_\_\_  
Signature & Title

\_\_\_\_\_  
(Name of program, if applicable)

**Appendix D: Interview Guide**

**1. Personal Information**

- a. Age
- b. Gender
- c. Race/Ethnicity
- d. Years in Foster Care
- e. Type of Placements
- f. Length of Time in Each Placement
- g. Current status or placement

**2. Experience of Mental Health Service**

- a. Did you receive any mental health services while in foster care?
- b. How was the decision to obtain mental health services made and by whom?
- c. How did you feel about how the decision was made?

**If participant received mental health services:**

- i. When did you receive mental health services and for how long?
- ii. What mental health services did you receive?
- iii. What were the mental health services like?
- iv. How did you feel about the mental health service you received?

**If participant did not receive mental health services:**

- v. Did you ever want or requested mental health services while in foster care? (Why or why not?)

**If yes:**

- 1. Why did you not receive mental health services?

**3. Current View of Mental Health Service**



- a. What thoughts or words come to your mind when you think of mental health services?
- b. Do you believe that mental health services are helpful? (Why or why not)
- c. Would you recommend mental health services to anyone? Why or why not?

**4. Future Use of Mental Health Service**

- a. Would you seek mental health services in the future? (Why or why not?)

**Appendix E: HSR Amendment Approval Letter**



**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 8, 2015

Sonia Aldape

Dear Sonia,

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

**Appendix F: Referral Sources for Participants**

1. [retracted]
2. [retracted]
3. Alcoholics Anonymous
4. [retracted]
5. Narcotics Anonymous
  - a. 24Hour Help & Info Line: 1-877-629-6759
6. [retracted]
7. [retracted]
8. California Youth Crisis Hotline
  - a. 800-843-5200 (May be delay)
9. Girls and Boys Town Hotline
  - a. 800-448-3000
10. National Suicide Prevention
  - a. 800-273-TALK
11. [retracted]