JOURNAL of PEDIATRIC NURSING

Official Journal of the
Society of Pediatric Nurses and the
Pediatric Endocrinology Nursing Society

EDITORIAL

Emancipation of Youth in Foster Care: The Dilemma

Currently, national estimates indicate that approximately 510,000 children and youth live in the foster care system. Of this number, 40% are between the ages of 13 and 21 years; about 9% of youth, amounting to 26,000, are emancipated annually from the foster care system (Child Welfare Information Gateway, 2009; United States Department of Health and Human Services [US DHHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families [ADYF], Children's Bureau [CB], 2008) The term *emancipation* refers to children who are emancipated as minors and have yet not achieved the age of majority (usually age 18 years) or have reached the age of majority (the statutory language varies and depends on state regulations). The criteria for determining emancipation status refers to the termination of eligibility for foster care services that are, for the most part, not predicated on the youth's readiness but rather on criteria based on age or high school graduation. The youth's readiness for emancipation is not based on developmental aptitude or maturity, although there has been widespread recognition of the need to better prepare youth for this monumental transition out of this service system (Sheehy et al., 2002). As the data indicate, these young people are not well prepared to assume the overwhelming responsibilities of adulthood. The outcome data of foster youth and alumni demonstrate that they fail to achieve comparable levels of education, encounter difficulties with employment and housing, experience adverse health outcomes, and engage in at-risk behaviors.

Academically, youth exiting foster care have lower rates of high school graduation and completion, lower high school achievement scores, problems with academic performance, and lower rates of college attendance (Burley & Halpern, 2001; Courtney, Zinn, Zielewski, Bess, Malm et al., 2008; Kushel, Yen, Gee, & Courtney, 2007; Raghavan, Shi, Aarons, Roesch, and McMillen, 2009). A study of 56 youth in foster care reported a range of problems associated with high school attendance. Within a 2-year period, 42.9% had been suspended or expelled from school, and more than 40% of the sample reported varied problems associated with school performance and conduct (Gramkowski et al., 2009).

These youth are at higher risk for homelessness and/or unstable housing and unemployment because they leave the foster care system inadequately prepared with the job and life skills needed to live independently and become self-sufficient (Kaplan, Skoolnik, & Turnbull, 2009; Kushel et al., 2007). Estimates of homelessness range from 14% to 58% (Kaplan et al., 2009; Kushel et al., 2007). Although the percentages vary depending on the methodology and sample used, the data indicate that homelessness is a significant problem for youth who have emancipated from the foster care system (Kaplan et al., 2009). The employment data reveal that individuals without their high school diploma or general equivalency diploma (GED) have higher rates of unemployment compared to high school graduates and those with some postsecondary education. Youth who are emancipated from the foster care system are a particularly vulnerable group for higher rates of unemployment due to the disproportionate higher percentages who do not complete high school. During times of economic recession/downturn, youth and young adults have been adversely affected with higher rates of unemployment and lower wages, putting emancipated youth from foster care at higher unemployment risk. For example, during the recession from 2001 to 2003, the youth employment rate dropped by 6.5%, and for young adults (20 to 24 years), the rate decreased by 3% (Sum, 2003).

Youth have higher rates of health and mental health problems. These problems include substance abuse, physical abuse, unmet health care needs, and higher rates of unintended pregnancy and incarceration (Kushel et al., 2007). Youth in foster care have disproportionately higher rates of behavioral health needs such as serious emotional disturbances, conduct disorder, separation anxiety disorder, and depression (Heflinger & Hoffman, 2008; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009; Zito et al., 2008). Estimates suggest that 50% to 75% of youth in foster care have behavioral health needs (Landsverk, Burns, Stambaugh, & Rolls Rentz, 2009). A report examining youth in foster care in the Northwest found

0882-5963/$ – see front matter
doi:10.1016/j.pedn.2009.11.005

that they had twice the rate of posttraumatic stress disorder compared to war veterans for whom this problem is well known (Pecora et al., 2005). A review of psychotropic medication patterns of youth in the Texas foster care system revealed a prevalence rate of 34.7%, which rose when computed for aggregate groups from 12% for early childhood to 66.5% for adolescents, ages 13 to 17 years, a rate higher than for other groups of youth (Zito et al., 2008).

A longitudinal study of foster care alumni revealed that the prevalence of mental health problems were significantly higher than in the general population (Pecora et al., 2009). Findings examining the mental health service rates of youth exiting the foster care system found that their access to mental health services declined precipitously by 60% upon their departure. Reasons given for the access problems were based on youth choice, costs, and deficit in self-management skills (McMillen & Raghaven, 2009).

Foster care youth and alumni have more health problems. A study of 188 foster youth found that they reported higher levels of health problems and high-risk behaviors (i.e., smoking, drugs). Furthermore, an association was found between the foster youth's at-risk health behaviors and that of his peers and nonparental adults who engaged in similar at-risk behaviors (Farruggia & Sorkin, 2009). Their health problems are exacerbated by access barriers to health care. In a study examining health insurance coverage of youth who exited from foster care, two thirds of youth lost their health insurance coverage; just one in six youth obtained health insurance after a mean duration of 8 months (Raghavan, Shi, Aarons, Roesch, and McMillen, 2009).

Experts have suggested that the mental and health problems that foster youth experience can be attributed to problems within the foster system of care itself. Problems include the lack of adequate training of foster parents and caseworkers to identify mental and physical health problems and refer them to appropriate resources in a timely manner and the lack of coordination with other service systems. Other problems identified are inadequate documentation of the youth's health history, discontinuities in care due to placement changes, and bureaucratic barriers of the systems of care (Farruggia & Sorkin, 2009; Mekonnen, Noonan, & Rubin, 2009; Schneiderman, 2008).

In response to the problems and challenges youth face, federal legislation, the John H. Chafee Foster Care Independence Program (US DHHS, ACF, ADYF, CB, n.d.), was enacted to provide funding and regulatory flexibility to the states for the development of emancipation programs for youth exiting foster care. As a result, a number of transition to independent living programs were developed to facilitate a coordinated and deliberative process for emancipated teens (US DHHS, ACF, 2006). However, the legislation guidance as to their actual implementation is not specified, resulting in significant variability of the programs themselves as to the instructional design such as content and format (Paul-Ward, 2009). Furthermore, the states have limited discretion in the allocation of funding (up to 30%) for housing and social services for emancipated youth, leaving many of them not covered. Reports indicate that approximately only 40% of eligible youth receive FCIA (Foster Care Independence Act) services (Courtney, 2005).

Despite the fact that for the past 20 years programs have been developed and implemented in foster care systems to facilitate their transition to adulthood to improve biopsychosocial outcomes, there has been scant evidence to demonstrate the extent to which these programs have been helpful, if at all (United States Department of Health and Human Services [US DHHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families [ADYF], Children's Bureau [CB], 2008). Problems identified with the programs have been the lack of transportation to access programs and the lack of hands-on experiences to reinforce the content presented on learning independent living skills such as managing a bank account (Paul-Ward, 2009; Sheehy et al., 2002; Workforce Strategy Center, n.d.). For example, experts suggest that transition preparation for postsecondary education need to include actual experiences that involve assistance and instruction on the process of college application, application for scholarships and tuition assistance, enrollment and registration assistance, and accessing college resources (Kaplan et al., 2009). A study of foster care alumni reported that nearly two thirds of the 216 students surveyed reported they had not been well prepared for postsecondary education (Merdinger, Hines, Osterling, & Wyatt, 2005).

The challenges youth in foster care face as they begin the formalized process of emancipation is formidable. What can pediatric nurses do to provide the assistance and support to better prepare them for emancipation? Actually, there are a number of actions that can be taken ranging from the provision of direct care to advocating for system change and conducting research that includes the testing of interventions that will effect positive outcomes (Kaplan et al., 2009).

This group of youth has serious health literacy needs as evidenced by the research findings pertaining to health and mental health unmet needs. It is important to take advantage of the "teachable moments" related to self-management of health and mental health needs. These youth need information about adopting healthy lifestyles, managing minor illnesses, learning to navigate the pediatric and adult health care systems, and understanding the meaning and application of preventive health measures.

As nurses, we can promote youth self-advocacy by encouraging them to speak for themselves pertaining to their health-related concerns. Youth need to feel supported to express current health concerns and those anticipated in the future to foster their active rather than passive involvement with health care professionals. Suggestions can be provided to help youth become better consumers of health care services such as listing questions for upcoming health care appointments to ask their health care providers and writing down or taping the essential information during their health visit.

As has been identified in the literature, youth who emancipate from foster care have had difficulties accessing community resources such as the Workforce Investment Act employment training and placement and the United States Housing and Urban Development Department housing programs that could help them achieve their goals for adulthood (Workforce Strategy Center, n.d.). Yet, what adolescent at this age, even under the best of circumstances, could be expected to navigate the complex service systems that experienced professionals in social services and adults have difficulties accessing? Nurses who are in service coordinator positions are in an ideal position to coordinate and refer the services youth need not only for health care services but for education, employment, and other adult services.

There are many more opportunities that nursing professionals can contribute to on behalf of foster care youth and alumni related to policymaking and research. It is important that policymakers hear from nurses as to what are the needs of youth in foster care and for pediatric nurses to encourage youth to find their voices to advocate for themselves to effect the necessary policy changes to improve the foster care system. Furthermore, nurse researchers are positioned to test interventions given their understanding of youth development, systems of care, and clinical practice. As nurses work with other colleagues and policymakers to effect changes related to practice and within the foster care system itself, hopefully services will be developed and implemented to more effectively meet the needs of emancipated youth.

Cecily L. Betz PhD, RN, FAAN
Editor-in-Chief
E-mail address: clbetz@aol.com

References

Burley, M., & Halpern, M. (2001). *Educational attainment of foster youth: Achievement and graduation. Outcomes for children in state care.* Olympia, WA: Washington State Institute for Public Policy.

Child Information Gateway. (2009). Foster care statistics. Retrieved on November 15, 2009 from www.childwelfare.gov.

Courtney, M. E. (2005). *Youth aging out of foster care.* Philadelphia, PA: MacArthur Foundation Research Network on Transitions to Adulthood and Public Policy.

Courtney, M. E., Zinn, A., Zielewski, E. H., Bess, R. J., Malm, K. E., Stagner, M., & Pergamit, M. (2008). *Evaluation of the early start to emancipation preparation-tutoring program, Los Angeles County, California, Final Report (Multi-site evaluation of foster youth programs).* Washington D.C.: The Urban Institute.

Farruggia, S. P., & Sorkin, D. H. (2009). Health risks for older US adolescents in foster care: The significance of important others' health behaviors on youths' health and health behaviors. *Child: Care, Health and Development*, *35*, 340–348.

Gramkowski, B., Kools, S., Paul, S., Boyer, C. B., Monasterio, E., & Robbins, N. (2009). Health risk behavior of youth in foster care. *Journal of Child and Adolescent Psychiatric Nursing*, *22*, 77–85.

Heflinger, C. A., & Hoffman, C. (2008). Transition age youth in publicly funded systems: Identifying high-risk youth for policy planning and improved service delivery. *Journal of Behavioral Health Services and Research*, *35*, 390–401.

Kaplan, S. J., Skoolnik, L., & Tunbull, A. (2009). Enhancing the empowerment of youth in foster care: Supportive services. *Child Welfare*, *88*, 133–161.

Kushel, M. B., Yen, I. H., Gee, L., & Courtney, M. E. (2007). Homelessness and health care access after emancipation: Results from the Midwest Evaluation of Adult Functioning of Former Foster Youth. *Archives of Pediatrics and Adolescent Medicine*, *161*, 986–993.

Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls-Reuts, J. A. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare*, *88*, 49–69.

McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. *Journal of Adolescent Health*, *44*, 7–13.

Mekonnen, R., Noonan, K., & Rubin, D. (2009). Achieving better health care outcomes for children in foster care. *Pediatric Clinics of North America*, *56*, 405–415.

Merdinger, J. M., Hines, A. M., Osterling, K. L., & Wyatt, P. (2005). Pathways to college for former foster youth: Understanding factors that contribute to educational success. *Child Welfare*, *84*, 867–896.

Paul-Ward, M. (2009). Social and occupational justice barriers in the transition from foster care to independent adulthood. *American Journal of Occupational Therapy*, *63*, 81–88.

Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare*, *88*, 5–25.

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., White, J., Hiripi, E., Roller-White, C., Wiggins, T., & Holmses, K. (2005). *Improving family foster care: Findings from the northwest foster care alumni study.* Seattle, WA: Casey Family Programs.

Raghavan, R., Shi, P., Aarons, G. A., Roesch, S. C., & McMillen, J. C. (2009). Health insurance discontinuities among adolescents leaving foster care. *Journal of Adolescent Health*, *44*, 41–47.

Schneiderman, J. U. (2008). Qualitative study on the role of nurses as health case managers of children in foster care in California. *Journal of Pediatric Nursing*, *23*, 241–249.

Sheehy, A. M., Oldham, E., Zanhghi, M., Ansell, D., Correia, P., & Copeland, R. (2002). *Promising practices: Supporting transition of youth served by the foster care system.*Baltimore, MD: The Anne E. Casey Foundation Retrieved on November 16, 2009, from http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid=%7BFCE9A9C0-8358-48FD-8349-33CD26925028%7D.

Sum, A. M. (2003). *Leaving young workers behind.* Washington, DC: National League of Cities.

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau. (2008). The AFCARS report. FY 2006 estimates as of January 2008. Retrieved on November 7, 2009, from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm.

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau (n.d.). John Chafee Foster Care Independence Program. Retrieved on November 19, 2009 from http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/jh_chafee.htm.

Workforce Strategy Center. (n.d.) *Promising practices: School to career and postsecondary education for foster care youth: A guide for policymakers and practitioners*. Baltimore: The Annie E. Casey Foundation.

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., Dubowski, M., & Mendez-Lewis, A. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*, *121*, e157–e3163.