Sarah Lawrence College

DigitalCommons@SarahLawrence

Health Advocacy Theses

12-2022

An Assessment of the Sexual and Mental Health Needs of Transition Age Foster Youth in New York City

Elizabeth Claessens
Sarah Lawrence College

Follow this and additional works at: https://digitalcommons.slc.edu/health_advocacy_etd

Part of the Mental and Social Health Commons

Recommended Citation
Claessens, Elizabeth, "An Assessment of the Sexual and Mental Health Needs of Transition Age Foster Youth in New York City" (2022). *Health Advocacy Theses*. 1.
https://digitalcommons.slc.edu/health_advocacy_etd/1

This Thesis - Campus Access Only is brought to you for free and open access by DigitalCommons@SarahLawrence. It has been accepted for inclusion in Health Advocacy Theses by an authorized administrator of DigitalCommons@SarahLawrence. For more information, please contact afreitas@sarahlawrence.edu.

AN ASSESSMENT OF THE SEXUAL AND MENTAL HEALTH NEEDS OF TRANSITION AGE FOSTER YOUTH IN NEW YORK CITY

Elizabeth Claessens

December 2022

Submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Health Advocacy
Sarah Lawrence College

An Assessment of the Sexual and Mental Health Needs of Transition Age Foster Youth in New York City

Elizabeth Claessens
Sarah Lawrence College
December 1, 2022

Abstract

Young adults age 18 to 21 who are transitioning out or “aging out” of foster care are an extremely vulnerable group who lack typical family support and preparation for independent adulthood. All transition age foster youth have been exposed to trauma and likely have had multiple adverse childhood experiences. This population is understood to have significant mental and sexual health risks. Foster care service agencies in New York City provide mental and sexual (reproductive) health care to foster youth as mandated by the state of New York. This needs assessment seeks to better understand whether those services meet the mental and sexual health needs of transition age foster youth in New York City. Interviews were conducted with five professionals currently employed by foster care service organizations and/or with direct experience working with foster youth. Several themes emerged from these interviews that highlight important areas of need for the sexual and mental health of transition age foster youth in New York City.

Overview

There are over 42 million adolescents and young adults aged 15 to 24 in the United States (Annie E. Casey Foundation, 2022). The vast majority of these youth will spend these years completing high school, attending college and/or acquiring job training, entering the labor force, forging social relationships, and gaining skills for self-sufficiency while relying on parents being available to provide some support (Courtenay & Hughes, 2005). Parents often provide support that helps young adults make potentially life-changing decisions, protects them from some risks, and allows them to take others. Intimate relationships in early adulthood are a key part of development and provide an important context in which to develop and integrate sexuality into a sense of self, apart from one's family (Courtenay & Hughes, 2005; Kusunoki & Barber, 2020). These relationships are an integral part of mental health and well-being.

In comparison, there are over 20,000 youth in the United States transitioning out of foster care each year with minimal or no adult support and guidance (Annie E. Casey Foundation, 2022). These youth have significant mental and sexual health risks as well as needs compared to their same age peers not in foster care. This needs assessment seeks a better understanding of transition age youth's specific mental and sexual health needs in New York City through interviews with professionals at foster care organizations and/or professionals who have worked with foster youth.

Foster Care and Transition

The majority of children and adolescents in foster care will eventually be reunited with family members, find permanent placement with non-family members, or be adopted (Villagrana, 2016). A small minority will fail to be reunified with family members, become adopted or find permanent placement. Youth who age out of foster care experience an abrupt transition from supports (psychological, educational, medical, social/emotional) provided by foster care agencies, schools and placements to expected adult self-sufficiency. To this point, the government has taken on the responsibility for parenting foster youth (Courtenay & Hughes, 2005). Between the ages of 18 to 21, if reunification or adoption have failed, the government declares foster youth to be adults, whether or not youth have the means or skills for self-sufficiency (Courtenay & Hughes, 2005). However, foster youth likely have little to none of the support same age peers have from family as they leave behind foster care agencies and group homes. These youth enter young adulthood at a significant disadvantage.

Presence of Trauma

All foster youth, regardless of age, have one thing in common: all have experienced trauma by being removed or separated from their family (Courtenay & Hughes, 2005; Nurius, Prince & Rocha, 2016; Rebbe et al., 2018). Many of these youth have experienced multiple other layers of trauma: poverty, physical or sexual abuse, parental incarceration, violence, mental illness, unstable housing, racism and/or exploitation (Blanks & Yates, 2016; Courtenay & Hughes, 2005; Kang-Yi & Adams, 2015; Nurius et al., 2016; Rebbe et al., 2018). Many suffer from mental and behavioral health problems (Blanks & Yates, 2016; Kang-Yi & Adams, 2015; Thompson & Auslander, 2011). Studies have shown a greater prevalence of emotional and behavioral problems in foster youth, as many as 80% are diagnosed, or four times the average of

similar diagnoses annually in the United States (Kang-Yi & Adams, 2015). Some have been rejected by their families of origin as a result of their sexual and/or gender identity (Baams, Wilson & Russell, 2019; Sandfort, 2021). Research has shown that the accumulation of trauma, or adverse childhood experiences (ACE's), over one's lifetime results in poor overall physical and mental health outcomes (Blanks & Yates, 2016; McCarty et al., 2013; Nurius et al., 2016; Rebbe et al., 2018). Indeed, the more stressors an individual has experienced in childhood, the more likely they are to suffer physical, mental, and substance related health problems in adulthood (McCarty et al., 2013; Nurius et al., 2016; Rebbe et al., 2018). It is difficult to imagine a population more vulnerable to these risks than transition age foster youth.

The relationships between types of childhood adversity and negative social determinants of health are complex, and among foster youth they create unique patterns and pathways of poor health outcomes and health risk (Nurius et al., 2016; Rebbe et al., 2018). Rebbe et al. (2018) studied the impact of adverse childhood experiences (ACE's) on the adult health of foster youth and found that greater numbers of adverse events resulted in poorer health outcomes and greater sexual risk taking. ACE's such as neglect, abuse and maltreatment further weaken psychosocial resources available to foster youth who need more intensive social support, and deeply impact self-perception (Nurius et al., 2016). Other research has shown a high number of ACE's to be associated with increased risky sexual behavior in adulthood (Blanks & Yates, 2016; McCarty et al., 2013; Nurius et al.).

Sexual Health Risks

The sexual health risks for this population are serious and there are many. Foster youth are at increased risk for early sexual debut, unplanned pregnancy, sexually transmitted infections (STI's), victimization and exploitation (Blanks & Yates, 2016; Kang-Yi & Adams, 2015; McCarty et al., 2013; Rebbe et al., 2018; Thompson et al., 2011). New York City's greatest increase in new diagnoses of both chlamydia and gonorrhea in 2020 was in males and females aged 15-24, predominantly non-Hispanic Black (NYSDOH, 2020). The racial demographics of the foster youth population in New York City are also predominantly non-Hispanic Black.

The age at which youth age out of foster care is the peak age for sexual risk, as well as what is understood to be general impetuosity and decision making that is present-focused and sensation-seeking (Inshell & Tabashneck et al., 2022; McCormick & Telzer, 2017. In young adulthood, engaging in risky sexual behavior that causes pregnancy, HIV or other sexually transmitted infections can have lifelong implications for later physical and mental health. Decision making regarding sex, including birth control and partners, but going further to include consent, ethics and behavior within intimate relationships, can have life altering consequences.

Blanks & Yates (2016) found that both childhood sexual abuse and returns to biological parents followed by returns to foster care (failed reunifications) were associated with increased sexual risk taking in female foster youth. A recent study of a national sample of 19- to 21-year-old females who had aged out of foster care found that 30% had given birth after aging out, and that one third previously had another child between the ages of 17 and 19 (Annie E. Casey Foundation, 2021). Having multiple children at a young age negatively impacts financial, educational, and employment possibilities for female foster youth, further limiting their chances of overcoming the enormous challenges of their youth in young adulthood.

Transitions in and out of care and failed reunifications may affect relational patterns and attachment and thus later sexual behavior (Blanks & Yates, 2016; McCarty et al., 2013). While higher rates of sexually transmitted infections (STI's) and pregnancy are well documented, female and LGBTQ+ foster youth are particularly vulnerable to exploitation and more likely to become involved in abusive relationships (Baams, Wilson & Russell, 2019; Sandfort, 2021). The propensity towards increased sexual risk in former foster youth is beginning to be understood through the mechanism of attachment. The instability these youth experience, the maladaptive attachments and failed family placements, and rejection, may negatively impact their ability to form relationships in adulthood but also cause them to look for belonging through sexual activity (McCarty et al., 2013).

Additional Factors

Teens who age out of foster care typically entered the foster system after age 15 rather than growing up in foster care. These foster youth are more likely to enter congregate (group) settings rather than being placed with relatives (Courtenay & Hughes, 2005; Curry & Abrams, 2014). Entering foster care in adolescence suggests years of childhood spent in very challenging circumstances prior to removal from one's family (Courtenay & Hughes, 2005; Curry & Abrams, 2014). In New York City in 2021, 85% of all age youth in foster care were African-American or Latino/a (OCFS, 2021). Criminal justice involvement and parental abuse are two of the most common reasons for foster entry in adolescence (Curry & Abrams, 2014; Kang-Yi & Adams, 2015).

Identifying as LGBTQ+ appears to be a significant reason teens enter care: their gender and/or sexual identity may not be accepted by family, leading to tension, abuse, and sometimes

rejection (Baams, Wilson, & Russell, 2019; Sandfort, 2021). Sandfort (2021) described these teens as particularly vulnerable foster youth. Most LGBTQIA+ youth in foster care in New York are Black and/or Hispanic, and while Sandfort (2021) found many were in communication with family members while in foster care, these youth were more likely to be in group residential settings and less likely to have consistent adults in their daily lives. Their deeper sense of estrangement and isolation caused higher levels of depression than other foster youth and may be related to their apparent greater difficulty with institutional systems- LGBTQIA+ youth were also more likely to be at risk for homelessness (Baams, Wilson & Russell, 2019; Sandfort, 2021).

Failing reunification with family or permanent placement is associated with poorer outcomes in adulthood, and particularly within this critical transitional period from adolescence (Blanks & Yates, 2016; Curry & Abrams, 2014; Lim et al., 2017). Adding to their vulnerability and further risking their safety, transition age foster youth are more likely to experience homelessness or housing instability (Curry & Abrams, 2014; Lim et al. 2017). Youth who age out have limited financial means or social support compared to their same age peers transitioning out of their family home. Many do not have the education or skills necessary to gain employment and afford housing on their own.

Current Conditions

New York City has a long history of providing care for poor, neglected, abused or orphaned children. Several organizations providing foster care services in NYC today were established in the mid-19th century to help poor and immigrant children. Most of these organizations began with and some continue to have religious affiliations. Religious affiliations can have an impact on what services organizations choose to offer beyond what is state

mandated, particularly in the realm of sexual health. Catholic based organizations, for instance, may not allow medical providers at their institutions to provide youth with birth control.

In 2021, 14,749 children were in foster care in New York State with roughly half, 7,601 children, in one of New York City's five boroughs (OCFS, 2021). In New York City, 2,173 children in 2021 were between the ages of 14 and 21 years of age (OCFS, 2021). An estimated 1,000 of the city's foster youth (aged 18 to 21) are emancipated or age out of foster care each year (OCFS, 2019; Transition Age Youth, 2017). In New York City, youth who identify as LGBTQIA+ are overrepresented in the foster youth population: 1 out of 3 (34.0%) foster youth ages 13-20 identify as LGBTQIA+, far more than the same age group not in care (Sandfort, 2021).

Children and youth in New York City enter the foster care system through the Administration of Children and Family Services (ACS) and their placements in foster homes of relatives (kinship) or non-relatives (non-kinship) are contracted by private non-for-profit agencies. Foster care placement outside the city in New York State is managed by the Office of Children and Family Services (OCFS). According to state government, the child welfare system in the state of New York in 2022 is "under transformation," from a focus of child protection to one of family assistance- assistance to help struggling families strengthen and remain intact (Hochul & Poole, 2022). Focusing greater attention on preventative services for families, individuals and communities is intended to reduce the rate of foster care admission, particularly for younger children. Awareness that more general social determinants of health such as poverty, discrimination, housing instability, food insecurity, access to medical care, and neighborhood safety cause inequity and disparity in referrals to foster care is growing and illustrated in New York state's new approach (Hochul & Poole, 2022).

Agencies are required and funded by New York State law to provide specific services to foster youth. Some of these non-for-profits are large organizations, with decades of experience serving children and families. These large organizations employ a wide number of professionals in addition to the many other staff who interact with foster youth regularly in non-professional roles, such as case managers. These organizations often have extensive psychological and psychiatric services focused on trauma-based therapy, as well as physicians and nurses who provide routine medical care. There is growing awareness of the overrepresentation of LGBTQIA+ youth in foster care agencies. Services for youth and training for employees and professionals reflect a growing understanding that inclusion and acceptance of all genders and sexual identities is in the best interest of foster youth and those who serve them. There are many points of contact for foster youth within these large organizations, and the people and spaces there can become meaningful to youth in the absence of stable homes.

Unmet Needs

State legal mandates for services, agency capability, and other restraints have made preventative and reproductive sexual health care the focus of sexual health services for foster youth in New York City and most likely everywhere. This is an understandable prioritization given the known risks. However, by focusing sexual health care on the mitigation of physical or medical risk, the government and organizations fail to see the impact, positive and negative, that sexual health and relationships have on mental health for this population. Arguably, the preventative focus reflects a less than optimistic view of their future, underestimating the growth and learning potential of young adulthood (Inshell & Tabashneck, 2022; McCormick & Telzer, 2017). Social relationships, especially intimate ones, take on special significance in the transition from adolescence to adulthood (Courtenay & Hughes, 2005; Hedenstrom, 2014; McCormick &

Telzer, 2017; Santa Maria et al., 2018). Beyond needing to understand safety and protection from STI's and pregnancy, young adults also need to learn about the social emotional aspects of relationships.

An essential component of sexual and mental health is the ability to forge and maintain successful social emotional relationships. Equity, consent and the skills to make ethical decisions are essential components of healthy relationships. Foster care agencies and organizations, in most cases, address many of the preventative sexual health needs of foster youth through their medical departments or with medical personnel. Are they able to provide youth with an understanding of eudaemonic sexual health (Lewis, 2004)? A eudaemonic understanding of sexual health understands sexuality as an essential part of human life that strengthens overall wellness through intimacy, connection and pleasure (Lewis, 2004). Racial minorities and the poor, which many foster youth in New York City are, have traditionally been seen as "at risk," for STI's, HIV and pregnancy- or in greater need of preventative sexual health interventions (Lewis, 2004). Socioeconomics and race may impact a more inclusive view of sexuality and the true needs of this population. This paper seeks to answer the following questions: what are the sexual health needs of New York City foster youth aging out of care? How does the mental health of New York City foster youth aging out of care affect their sexual health needs?

Foster youth aging out of care are already introduced to adulthood with an unfair number of burdens. The dominant American values of autonomy and "pulling oneself up by the bootstraps," create unrealistic expectations for foster youth without much support, who age out of care into one of the most expensive cities in the world (Curry & Abrams, 2014). How will these youth make their way in the world if we do not also try to address and support their need for emotional and physical connection? Providers and agencies are for the most part well

equipped to provide standard preventative and medical sexual health care. However, trauma experience complicates foster youth's interactions in and ability to form stable healthy relationships. Are the sexual and mental health needs of foster youth being met by the current care model? If not, how will these needs be met?

Methods

The data informing this needs assessment was collected through one-on-one virtual interviews. Due to COVID-19, social distancing and other access constraints, speaking directly with transition age foster youth regarding their sexual and mental health needs was not possible. Speaking directly with this population in focus groups and individual interviews is a goal for future study. Instead, the research design shifted to focus on interviewing key informants who work directly with foster youth. These key informants could speak to their perceptions and understanding of the sexual and mental health needs of transition age foster youth in New York City.

Prior to commencing this study, I had minimal knowledge or understanding of the New York City foster system and the experiences of foster children and young adults. Through my prior training and work in nursing and my graduate study of psychology, social work and health policy, I began this project with a firm background in the impact of trauma, adverse childhood experiences (ACEs), and social and environmental health on children's mental and physical health. This prior understanding helped inform construction of the interview questions and gave me familiarity with the professional roles of individuals I interviewed. This background also provided a knowledge base that assisted in synthesizing and integrating the information gleaned

from participant interviews about the foster care system and individual experiences that were novel to me.

Recruitment for participation in subject interviews was conducted via word of mouth exclusively online and/or via email. Initially the project design sought the participation of foster youth ages 18-24 and individuals in roles supporting foster youth for a minimum of ten interviews. Due to the personal nature of the information sought for this project and the vulnerability of the target population, a decision was made not to blindly contact organizations working with foster youth and request interviews with personnel. Privacy concerns were also considered. Some participants were recruited through personal and professional connections to Sarah Lawrence College. The COVID-19 pandemic required a shift to all virtual interviews and a transition to non-foster youth interviews only due to issues of access and difficulty with recruitment. Prior to recruitment, institutional review board (IRB) exemption was secured from Sarah Lawrence College. Prospective interview subjects were sought as a result of their professional experience and/or roles working directly with foster youth/young adults at agencies and organizations focusing on work with this population. A variety of individuals in different professional roles (social work, mental health practitioners, medical staff, administrators, milieu workers) were desired as participants. The recruitment resulted in a higher percentage of individuals in mental health professional roles (social worker, psychologist, mental health nurse practitioner). No number of participants was predetermined; however, the initial project proposal sought a minimum of ten participants. Snowball selection was intended after the initial interviews. Due to the difficulty of recruiting participants virtually, recruitment was very limited. The number of total participants is limited by who responded to requests for interviews. It was also limited by the failure of the intended snowball selection. All interview subjects agreed to

and passed along information about this project to coworkers/peers at their organizations to elicit their participation. Ultimately the five interview subjects represented only two large foster care and social services agencies.

Prospective interview subjects were not offered incentives or compensation to participate. All individuals were provided with a consent form via email prior to the scheduled interview. The consent form detailed the interview procedure and duration, audio and video recording and confidentiality. All individuals who agreed to participate signed the consent form (attached as appendix A). All individuals who agreed to participate also completed a brief demographic survey detailing their gender, race, educational level, professional role, and number of years working with foster youth (attached as appendix B). Additionally, participants were asked to complete the adult version of the MacArthur Scale of Subjective Social Status (see appendix B). The MacArthur scale is a visual representation of a ladder. Participants in this project were instructed to imagine that individuals at the top of the ladder are the best off as determined by markers of socioeconomic status such as wealth, education and job category, while individuals at the bottom of the ladder were the worst off socioeconomically. Participants were asked to choose the rung on the ladder that best represented where they saw themselves in relation to society at large.

Participant 1 is a White cisgender male in his thirties who works at a large non-profit offering a large variety of programming and support to foster youth and families. He is a Psychiatric Nurse Practitioner with both a master's and professional degree in nursing. At the time of the interview, participant 1was in his fifth year working with foster youth, but had been at his organization in his current role for just under one year. Participant 1 works with foster

youth ages 6-23, but reported only working with three individuals in the target age group. On the demographic survey, participant 1 classified himself as a "6-7" on the socioeconomic ladder.

Participant 2 is White, identifies as genderqueer using "they/them" pronouns, and is in their late 20s. They work at a large nonprofit supporting foster youth and families. Participant 2 is a Clinical Psychotherapist with a master's degree and has been at their organization and in their current role for five years. Their role supports foster youth from infancy to age 21. On the demographic survey, Participant 2 classified themselves as a "7" on the socioeconomic ladder.

Participant 3 is a White cisgender female in her 40s. She has worked in a variety of mental health and leadership roles at a large non-profit child and family service agency for over ten years. She has both a master's degree and doctorate in Clinical Psychology. She has worked with foster youth of all ages but at the time of the interview worked directly with youth ages 13 to 21. On the demographic survey, Participant 3 classified herself as an "8" on the socioeconomic ladder.

Participant 4 is a White cisgender male in his 20s who is in the process of completing his master's degree in social work. He spent a year working with foster youth ages 18 to 24 as a social work intern at a large non-profit child and family services agency, in a residential setting. On the demographic survey, Participant 4 classified himself as a "7" on the socioeconomic ladder.

Participant 5 is a Black cisgender male in his 50s. He has a master's degree and doctorate in developmental psychology, as well as training and experience in clinical psychotherapy. He is a professor of psychology with expertise in the sexual development of minority adolescents and

adults. He teaches and trains undergraduate to doctoral students at colleges, universities and in clinical settings. On the demographic survey, Participant 5 classified himself as an “8.”

The interview guide was intended to elicit thoughtful and extensive reflections from participants. All questions were designed to be open-ended. The first prompt at the beginning of each interview asked participants to explain the meaning of sexual health to them as an individual. Then participants were asked their thoughts about how the foster youth they have worked with would define sexual health. After establishing a basis for understanding the concept of sexual health, each participant answered a question that asked what sexual health needs they identified as the most pressing in the foster youth population. Multiple prompts were drafted as follow ups to central questions, however, the interview guide was intended to be flexible and to follow the narrative lead of the participant. Additional questions asked participants to describe how well they thought their organizations were able to meet the sexual and mental health needs identified. The interview guide is attached as appendix C. All subject interviews were conducted online with virtual conferencing through Zoom. Each participant was asked to commit to a 60-minute interview, interviews varied from 35 minutes to one hour. All interviews were conducted privately from my own home with no one else present. Each interview was audio and video recorded and saved to the Cloud with a unique and anonymous participant identifier. Each audio file was then transcribed through the online service Otter AI. The resulting transcripts were then downloaded and saved locally on my computer, each again with a unique and anonymous identifier. Once this was completed, each transcript was “cleaned” and edited for ease of future review only, no participant narrative was removed during this process.

Results

For the purposes of this needs assessment, the sexual and mental health needs identified by participants will be classified using Bradshaw's (1977) need domains. Bradshaw described four domains of psychological need: normative, felt, expressed and comparative. All of the needs described here by participants are normative needs, as all participants are experts and/or professionals working directly with foster youth. This paper is unable to address the felt needs New York City foster youth might express to service providers or others involved in their care because no foster youth were interviewed as part of this study. Expressed needs are needs for which there is a demonstratable and/or vocalized demand. Interview subjects were able to speak to some of the expressed sexual and mental health needs of New York City transition age foster youth as a result of their professional experience. Comparative needs can be understood by looking at details of a population's specific needs in relation to a comparable larger population. The needs of New York City transition age foster youth should be compared to the general population of adolescents transitioning to adulthood.

The interviews identified six dominant topics and/or areas of sexual and mental health needs for New York City transition age foster youth. Using Bradshaw's (1977) domains of psychological need (normative, felt, expressed, comparative) all six themes represent normative needs as expressed by experts and/or stakeholders. In some cases, participants could speak to needs directly expressed to them by foster youth. Direct quotes appear below in relation to each of the six themes.

To provide context for the interviews, I asked each participant the following question: "When you think about sexual health, what do you think it means?" All participants in direct working relationships with foster youth referenced education or acquiring information in their

response. Four out of the five participants used the phrase “asking questions” or the words “knowledge” or “learning” to describe sexual health. Education dominated the responses to this question. When participants described the sexual health needs of the foster youth in their care, birth control/contraception and education predominated. Nearly all participants described preventive sexual health care (birth control, sexual education, gynecological care) as the priorities of need. Nearly all participants described preventive sexual health care when defining what sexual health means to them as individuals. Education was described broadly as covering a variety of sexual health related topics. Participants frequently mentioned youth in care lacking basic knowledge and understanding of their anatomy or procreative sex, topics in sexual education traditionally provided either by educational institutions or family members. Consent and decision making frequently came up with participants as areas where foster youth lacked experience or education. Participants saw foster youth as struggling with both giving and seeking consent. In the course of the interviews, several participants linked mental health needs directly to problems with consent and decision making in sexual relationships.

Trauma experience and sexual health needs overlapped in multiple ways. One participant described a broader concept of sexual well-being that included consent and the understanding of one’s own body and how it relates to someone else’s. Participant 4 referred to biological sexual health and the presence of absence of disease either physically or psychologically in their definition. Participant 1 described sexual health in general as a “moving target,” based on age and experience. Several participants mentioned that foster youth would define sexual health in similar terms, with education and access to information figuring prominently in youths’ definition of sexual health. Safety, birth control, and STI treatment also came up in response to this prompt. Participant 5 made a point of saying sexual health meant much more than sexual

behavior. The interpersonal and psychosocial aspects of relationships, as well as issues of equity and morality were included in their concept of sexual health.

Trauma

Trauma was by far the most prevalent theme in all participant interviews. All participants understand foster youth as a group all of whom have been exposed to trauma(s) by virtue of being in care. Trauma experience and trauma history are a common thread mentioned in connection with all other themes and discussion of foster youths' sexual and mental health needs. Four out of five participants are engaged in therapeutic work with foster youth. In their professional roles, these participants view psychological/psychiatric treatment to address trauma as the priority normative health need for foster youth. Any individual sexual or mental health need must be understood in the context of underlying trauma, therefore reducing the burden of trauma through therapy or other means must happen first. Transition age foster youth have a much more significant comparative need for psychological and/or psychiatric therapy to address trauma than non-foster youth adolescents in the same age group.

> "We know every youth who comes into care has suffered at least one form of trauma at a minimum…being removed from their primary caregivers." (Participant 2, 5 years of experience)

> "…we really focus on their attachment trauma, so much of their mental health challenges are relational in nature and are expressed through their relationships with other people. General distrust of others based on a lot of their attachment disruptions. I could go on for hours about it." (Participant 3, 10 years of experience)

> "Just about every youth I saw…probably had some type of psychiatric diagnosis. And I mean, most of them had extensive trauma histories." (Participant 4, 1 year of experience)

> "I think that what we as a field really failed to talk about is the fact that no matter what the reason was to have a child removed from a home, that's trauma. The way the foster care system is set up right now, there's kind of normal regular

> foster care, and then there's TFC, you know, trauma focused care. It takes a psychiatric evaluation, as well as quite a few other documents to step them up to TFC." (Participant 1, 5 years of experience)
>
> "Their history matters a whole lot. Sex is a scary topic for people who have been abused, not just sexual abuse, but you know, abuse causes problems in developing safe relationships. You know, sex when it's not something you're familiar with, generally can be scary on its own. But then you add in this piece, that's it's also very intimate, it requires connection, it requires you to become vulnerable on some level. It's a really scary prospect. Talking to somebody about sexual health, about sexual relationships, about relationships in general, is a very different thing for someone who's experienced that trauma or abuse than for someone who hasn't." (Participant 1, 5 years of experience)
>
> "A lot of youth, it's almost axiomatic, one of the reasons why they're in foster care is because they've encountered trauma and that trauma has had an effect. It will have an effect… on how they're interacting and living in the world. So, there's a lot of stuff that has to be done, you know, in helping kids to move towards a place where they can have more positive outcomes in their lives in general to relieve the stress." (Participant 5, 14 years of experience)

Consent

Several participants mentioned the topic of consent in relation to sexual and mental health needs. This topic is directly connected to other normative needs described here: trauma and healthy relationships/connection. Participants understood consent to be more than a sexual health topic and acknowledged that it is not a major topic of school based sexual education. An understanding of consent was described as necessary for personal safety, safety of others, maintaining ownership over one's body, and sexual risk taking. One participant highlighted that institutionalized youth, some with cognitive disabilities and/or severe mental illness, are especially lacking in an understanding of consent. This participant pointed out that cognitively impaired or institutionalized foster youth are the least likely to be exposed to the topic of consent as part of any sexual education. Transition age foster youth have a comparatively greater need to understand the topic of consent than same age non-foster youth.

> "…the trend with patients that I've worked with, in the past or in that age group, has really been ongoing conversations about consent…consent is not something that's discussed very deeply in sexual education…and that's caused problems in their life that, you know, opens them up to risks for themselves and risks for those who are partnered or decide to have a relationship with. Consent is not just a sexual topic." (Participant 1, 5 years of experience)

> "But with the ideas that are concerned in sexual health, you know, you should not just talk about consent in this, you should talk about it everywhere, you should not just talk about protection, you should talk about it everywhere. It should be an ongoing understanding of a topic that you're used to and familiar with. So, I think that's probably our biggest issue right now is that we're not just teaching sexual health, we're teaching the topics that are involved in sexual health, and then trying to expand on those ideas, which is, you know, certainly not something you do in a couple of weeks, or a month or a year." (Participant 1, 5 years of experience)

> "…I think we're all encouraging our youth, especially because they potentially have been abused in some way or suffered some form of neglect, we want (them) to know ownership over your body. But that conversation of consent is happening from our medical department… (it's not) something that we stress in our mental health department." (Participant 2, 5 years of experience)

> "Some of them are institutionalized because of intellectual cognitive disability, so issues of consent become important there, how can they consent, can they consent, what are you able to comprehend, you know. But also, this is connected to their emotional lives that may or may not have a connection to their cognitive ability." (Participant 5, 14 years of experience)

LGBTQIA+

Foster youth identifying as LGBTQIA+ were described by participants as having a comparatively greater burden of need for sexual and mental services to both the general foster youth and non-foster youth populations. One participant observed (citing the Columbia University Report) that LGBTQIA+ youth were disproportionally represented in the NYC foster youth population. Participants acknowledged that LGBTQIA+ youths' sexual health needs in particular are neither appropriately considered or adequately addressed. Participants noted these youth are less likely than their peers to express specific needs and more likely to feel isolated.

> "While they do get some sexual education in school…there's a lot of questions that aren't answered, so often in individual therapy questions and sexual health and sexual issues come up. Especially for kids who are gender non-conforming, trans, part of the LGBTQ+ population, those all come up a bit earlier." (Participant 1, 5 years of experience)

> "…we have…our Acceptance Board. It's a training program for the youth specifically and to connect them to programs in which they can learn and make peer relationships and really have a social interaction that's safe." (Participant 1, 5 years of experience)

> "I put forward the idea that we are underserving out LGBTQ youth, because we know that that's a high need population within foster care. In November of 2020, ACS put up a survey that was published saying, here's how many youths identify and here's what this need really is. And so, since then, our department has really been backing the Identity and Acceptance program I had proposed." (Participant 2, 5 years of experience)

> "…and we recognize that in an educational setting, a lot of youth don't get comprehensive sexual education that goes towards who they are, if they're queer, trans identified. So, we've recognized that that's a huge lapse…" (Participant 2, 5 years of experience)

> "Having comprehensive sexual education that fits for everybody, whether that's…queer, or trans identified, or -cis and straight identified…even if you are asexual, you might still have sexual health needs. That's something often overlooked." (Participant 2, 5 years of experience)

Responding to a prompt asking what could change to better serve their LGBTQ+ youth:

> "…discussing around advocating for birth control to be discussed with their clients. I know that might not seem like something that's important for LGBTQ+ youth. But it's actually something that's so critical, because if the youth is having dysphoria every month because of their menstrual cycle, being on birth control could stop that. And that could be a huge lift to their mental health needs right there." (Participant 2, 5 years of experience)

> "…LGBTQ+ youth are definitely part of, you know, our thinking in terms of specific needs. So, we did have the therapy group this year. What else can I say about it? I mean, I think that it's part of the training, right?" (Participant 3, 10 years of experience)

> "…youth who were LGBTQ+, I would definitely say there was a lot of, definitely a very added layer of complexity and problems, I don't know if there was anything specific, it was generally incorporated into that sort of knowledge we would teach them about relationships and sexual health in general…We'll

> definitely address that there's a spectrum of relationships people can have in attractions and gender." (Participant 4, 1 year of experience)

What does a healthy relationship look like? / Connection

This theme emerged from the participant interviews in a variety of ways without being specifically named. Several participants acknowledged the complexity of forming healthy relationships with a history of trauma, absence of adult mentors or typical models for healthy relationships. Participants understood trauma to directly impact foster youths' views of relationships in general. Participants described foster youth lacking trust in psychological providers like themselves or other agency personnel due to the short-term nature of many of their interactions with adults. One participant linked youths' trauma experience with an intense need for self-protection that can conflict with successful platonic and romantic relationships.

> "…it's important to note that kids in the foster system don't trust easily and they expect relationships to be short term: this is what they've been taught, this is what they have found to be safe." (Participant 1, 5 years of experience)

> "…trauma, no matter what abuse, no matter what type they've experienced, causes you to question relationships, and worry more about protecting yourself, getting your needs met. And when you're worried about those things, it's harder to look outside of yourself. And to really think like a partner, in an intimate relationship, you have to look outside yourself, right? You can't do that while only looking inward." (Participant 1, 5 years of experience)

> "…sexual needs absolutely exist. When they start existing in a framework where you're worried about getting what you need, that can be a real problem. Because we haven't gotten a chance to talk about, like, how you do that safely? … (foster youth) tend to see people as ways to get what they need and not as individuals outside of themselves, which can be really difficult because when you're trying to form a bond with anybody, a friend, or romantic partner or parent, whatever it is, you know, you can't see them as a tool and an important emotional figure in your life at the same time. One negates the other, because it would require you to be vulnerable. And you've already learned that you can't be vulnerable because no one will provide for your needs." (Participant 1, 5 years of experience)

> "Many of our youth, particularly our young women, tend to think they're unlovable and so often use sex as a way of connecting with others and then

> feeling loved. Sex replaces affection for many of them. We also work with a number of youths who are connected to the CSEC [commercial sexual exploitation of children] world or sexually exploited. So, we see a lot of that as well." (Participant 3, 10 years of experience)
>
> "I think things that maybe a typical youth could ask their parents or their family physician, or somebody that they know and have a relationship with, I think for our youth, there is no such person some of the time…we have an entire medical department, and they are the ones to speak to, but there's a turnover…those people change. There aren't these like long lasting relationships and people to speak to about these things." (Participant 3, 10 years of experience)
>
> "There's attention to talking to youth about sexuality in…a therapeutic context, but they also need the regular stuff that other kids should get around sexuality and ethics and thinking about how they interact with other people. So, I think that in some ways, if we don't think about it in a principled way, it becomes…it's all left up in the air, and that's a big problem." (Participant 5, 14 years of experience)

Underutilization of services by foster youth

The underutilization of services was mentioned in several interviews. Participants expressed that their organizations offered many services for youth related to mental and sexual health, but despite the perceived normative need, foster youth often chose not to use them. Participants providing psychological services to foster youth all expressed satisfaction with the mental health services their organizations currently offered. These participants expressed that transition age youth did not take full advantage of the organizations' services in general, but also declined sessions with professionals like themselves, did not complete their course of therapy, or did not attend support groups. Participant 4 recounted that older youth frequently left the residential setting to "do whatever they wanted to do without consequences," but did not have the skills for independence and would sometimes return weeks or months later. More than one participant expressed there appeared to be a mismatch on different levels of the services offered and what foster youth took advantage of. Although they did not link this issue to underutilization

of services, participant 2 acknowledged that the religious affiliation of their organization (Catholic) restricted both potential conversations with youth as well as access to birth control.

> "The (foster care) industry has a struggle with the difference between providing resources and helping people make use of those resources. …we can provide all the training, conversation space…private meetings with medical professionals that we want, if somebody's not open to that information, it's not going to be used." (Participant 2, 5 years of experience)
>
> "We are available to meet those (sexual health) needs. It's really a matter of whether youth are open and forthcoming with us about what their needs are. It's really just a matter of the utilization of their nurses." (Participant 3, 10 years of experience)
>
> "They (foster youth) had a lot of access to resources they need. They have autonomy in the sense that they can decline the services and very often that would happen." (Participant 4, 1 year of experience)
>
> "…it was a very complex phenomenon, because on the one hand, there's definitely a deep dislike for being there and being detached from their family. One the other hand, I noticed from talking to coworkers, it seemed a lot of the youth also had a sort of reliance on being there as well." (Participant 4, 1 year of experience)
>
> "Professional staff is you know, middle class and largely white and largely female. The male staff, the people who work directly with the residents the kids and residents and they also have different arms of the of their organization that works in a non-residential sense. I got a sense of that their milieu staff was mostly BIPOC folks who often had a bachelor's degree, but not necessarily and then the foster youth who were almost all youth of color. (Participant 5, 14 years of experience)
>
> Participant 2 on the impact of their agency's religious affiliation on sexual health services:
>
> "I think with sexual health at our agency, we are a Catholic agency, we are not allowed to discuss birth control, we are really only allowed to discuss family planning options when it comes to our youth. So, we've recognized that that's a huge lapse that not just our educational system has, but especially our agency when we're restricted on what conversations our nurse practitioners can be holding with some of our youth."

Adaptive Decision Making

This theme emerged from the broader discussions of the themes of trauma, consent, healthy relationships and what transition age youth lacked in comparison to same age peers not in foster care. This is a normative need most participants alluded to when discussing other sexual and mental health needs, but not directly voiced. One participant discussed decision making as an essential feature of healthy relationships, particularly related to ethics, behavior, morality and intimacy. This participant discussed decision making in the context of broader sexual education and what environment youth lived in. Two participants specifically linked attachment trauma to sexuality and relationships. One participant linked social media use to adapted decision making, sexuality, need for connection and consent among transition age youth. This participant viewed female foster youth's technology use as especially dangerous: their risk of abuse, victimization and/or exploitation was notably greater than the general population. The social work masters' student highlighted normative needs for economic skills and housing assistance prior to aging out, and these needs directly connected to youths expressed need for safety and ability to make better decisions. The need for assistance/education around adapted decision making in relationships but also life in general is substantially greater than the general population.

> "They find their romantic partners through social media, unfortunately. And so, there's, you know, a lot of sexting. There's a lot of sending pictures. There's a lot of misuse of their tech (technology), that can be very dangerous to our youth that is sexual in nature." (Participant 3, 10 years of experience)

> "They tend to get very quickly and easily attached to others. Many of our youth, particularly our young women, tend to think that they're unlovable and so often use sex as a way of connecting to others and then feeling loved. Sex replaces affection for many of them. We also work with a number of youths who are, in some ways connected to the CSAC [commercial sexual abuse of children] world or sexually exploited." (Participant 3, 10 years of experience)

> "One thing I think that is really left out often, is how do foster youth get comprehensive sexual education. They may or may not get it in schools,

depending on what school they go to. They may or may not be getting it in their homes, with their foster families, foster parents, or foster guardians, but also in an institution. I think that often decisions that are connected to morality, so to speak or ethical decisions are often left by schools to be made in the home. Sometimes kids are not in their homes or families of origin because their families are having challenges. And they may not be getting that kind of discussion about ethics and things like that in other places, because they are kind of in a liminal state. And also, some kids are in the system because they have been exploited sexually." (Participant 5, 14 years of experience)

"We often think that you know folks who are coming from backgrounds that are discriminated against, I think one of the ways in which we discriminate against them is to think of them as not having a moral compass. Like what we think about young people, and how they're thinking about sex and sexuality. I think that young people also think about not hurting their partners, and try to think about what is the right way to be in a relationship, and be authentic about relationships. They don't necessarily do things because they're impulsive, or they're not thinking and not planning their lives." (Participant 5, 14 years of experience)

"Definitely when we talk about things that are attached to the deployment of sexuality, how do you, do things like interact respectfully, and with someone else, how do you know a relationship is not working in a way that is healthy for you, that's the kind of thing that people think about for therapists or you know for parents and they don't think about it as being something that can be that can or should be taught and it's worse for institutions because liability." (Participant 5, 14 years of experience)

"A big piece, I've noticed, safety was a big theme. And psychological in the sense of one's own appraisal of their ability to do well. We had youth that would get placed somewhere, but they were like, I can't go there, because it's in a really bad neighborhood. And a lot of them came from very bad neighborhoods and turn to crime. And some find it traumatic, they just don't want to, you know, they're trying to be out of those sorts of dangerous places." (Participant 4, 1 year experience)

Discussion

The comments and themes that emerged from participant interviews clearly reinforce and illuminate the many vulnerabilities of transition age foster youth in New York City. Trauma, consent, identifying as LGBTQ+, healthy relationships and connection, service underutilization and adapted decision making are interconnected with transition age foster youths' mental and sexual health needs. These youth face monumental risks while carrying heavy burdens. Several of the many understood risks of transition age youth, poverty, homelessness, incarceration, are beyond the scope of this paper, but are important to mention because they are directly connected to sexual and mental health.

Mental versus Sexual Health Needs

The interviews demonstrated that foster care and social services agencies in New York City are more focused on and successful at meeting the mental health versus sexual health needs of foster youth ages 16-21. Participants all described foster youth clients with extensive trauma histories, many with psychiatric and/or behavioral disorders who required long term therapy and medication. Their organizations provided these services. The five professional participants involved in therapeutic services for foster youth in this needs assessment all work for two organizations that have shifted to a trauma focused model of care in their clinical interactions with clients. All participants had knowledge of and/or training in trauma focused cognitive behavioral therapy; an evidence-based modality that focuses on the needs of children who have experienced traumatic events.

Trauma

The mental health needs described by participants centered on trauma focused therapy and ongoing psychological care and treatment. Another dominant need mentioned was for secure attachment. Participants described youth without secure attachments to parents (biological or foster) or other adults as a result of foster placement or other disruptions in their childhood. The lack of secure attachment and resulting need for self-protection and self-reliance was understood by participants to affect all aspects of mental health. Several participants described foster youth whose mental health needs were predominantly relational in nature due to the absence of secure attachment. The extreme need for attachment made the therapist relationship (most participants were involved in psychological care) particularly meaningful. Participants also mentioned a need, intensified by the COVID-19 pandemic and the ensuing disruption to in person services, for an attachment to a reliable and comfortable physical space. Several participants noted that foster youth are often diagnosed with behavioral or emotional disorders (i.e., attention deficit hyperactivity disorder, oppositional defiant disorder, major depression), that present symptomatically similarly to trauma. Several participants questioned whether their foster youth clients would be diagnosed with these disorders were it not for their trauma experience. This observation leads to multiple questions about potential outcomes for foster youth as well as appropriate treatment. Being able to directly address and treat the underlying trauma was seen as more both more important and more likely to succeed than medication alone. Clinical professional participants expressed uncertainty regarding mental health care follow up when their foster care clients age out.

Research shows Black and Latino foster care children and youth are less likely to utilize mental health care services, and that usage of mental health service sharply decreases after

discharge or transition from the foster care system (McMillen & Raghavan, 2009; Villagrana, 2017). Mental health disorders and trauma are well understood to exacerbate the risks and poor outcomes for transition age foster youth, and neither disappear or cease to be individually relevant between the ages of 18 to 21 (Blanks & Yates, Nurius et al., Villagrana, 2017). Youth aging out in New York have Medicaid coverage until age 26. Improved transition planning for mental health services as well as deeper linkages with their community and supportive adults could positively impact their success upon transition out of foster care.

Consent

Understanding of consent is a normative sexual and mental health need for transition age foster youth. Participants mentioned consent in multiple contexts. Three participants identified consent as a concept that transcends sexual health and one with great significance for youth with trauma experience and/or in institutional and residential settings. Other participants implied the concept of consent when discussing safety (from victimization, exploitation) and "ownership of one's body," This implies a need to expand the current understanding of sexual health for transition age foster youth beyond preventative and/or reproductive sexual health. Generally, participants agreed consent was not a standard part of school based sexual education, nor was school based sexual education something transition age youth could be expected to receive. If understanding consent is necessary for sexual health and other areas of adult life, where will transition age foster youth learn about it and who is responsible for providing the education?

The provider participants viewed most sexual health topics and education as the domain of their medical departments and specifically nurses. It is unknown if nurses regularly have conversations about or answer questions about consent with their adolescent foster youth

patients. If understanding consent is essential for sexual health and relationships, then it should be purposefully integrated into a variety of contexts for transition age youth. Understanding consent in relation to ones' self and others should be a fundamental component of sexual health that also meets the unique mental health needs of this population. Transition age foster youth have a greater need to fully understand consent as a result of their trauma experience and increased sexual risk. A discussion of consent in relation to mental or sexual health risk for transition age youth has not been found in the academic literature.

LGBTQ+ Needs

LGBTQ+ identifying transition age foster youth emerged as a theme in interviews due to their known overrepresentation in New York City and their complex sexual and mental health needs (Baam, Wilson & Russell, 2019; Sandfort, 2021). Many of these youth New York City are also racial minorities (Sandfort, 2021). Within their residential setting (kinship or non-kinship placement, group setting), but also specifically in the provision of services at the organizations foster youth encounter, acceptance was described as the priority by participants. LGBTQ minorities are known to experience more isolation (from family and social networks) and lack trust in medical providers, for both historical and cultural reasons (Santos et al., 2017) One organization is moving towards providing more services for this population. Participants employed by the second organization were less aware of specific interventions targeted towards LGBTQ+ transition age youth, but were certain professionals and employees received training and that their institution modelled acceptance. LGBTQ+ foster youth tend to enter foster care later, and in New York, tend to experience both more care placements that are either group residential or non-kinship (Sandfort, 2021). Sandfort (2021) describes LGBTQ+ foster youth in

New York City as more likely to feel isolated, depressed and pessimistic about their futures after care than non-LGBTQ+ foster youth.

While participants were mostly aware of the overrepresentation and prepared to address mental health, their organizations were less aware or ready to meet LGBTQ+ youth specific sexual needs. Usage of correct pronouns, LGBTQIA + focused peer groups and/or meeting spaces, connection to gender affirming community services and resources, and were some of specific needs participants mentioned. Homelessness, victimization and substance abuse are significant risks understood to be greater in LGBTQ+ youth aging out of foster care (Baams, Wilson & Russell, 2019; Sandfort, 2021).

Need for Healthy Relationships/Connection

Trauma and insecure attachment cause some foster youth to engage in risky sexual behavior, leading to higher rates of pregnancy and sexually transmitted infection that have been well documented in the literature. This supports participants stress on the need for preventive sexual health care. However, some participants also described the impact of trauma on how foster youth define or conduct healthy relationships. Trauma, as discussed earlier, can cause a variety of problems in forming relationships. What are healthy relationships and what do they look like? Many foster youths lack examples of healthy relationships of all kinds. This is the kind of experience or mentorship typically gained from a parent, caregiver or other trusted adult. Related to both consent and healthy relationships, one participant cited the need for understanding sexual responsibility or ethical sexual behavior.

The impact of trauma and foster care experience on youth’s need for connection and healthy relationships was a consistent theme in participant interviews. Participants described

transition age youth who are accustomed to short-term, transactional relationships with adults and have difficulty trusting others but are deeply in need of connection, intimacy and affirmation. One participant described female foster youth seeking this connection in sexual encounters, and by means that put them at risk for victimization and/or exploitation. These risks are well supported by the literature, and the sexual risk for female foster youth is known to be high (Blanks & Yates, 2016; Hedenstrom, 2014; Kang-Yi & Adams, 2015; Lim, Singh & Gwynn, 2017; McCarty et al., 2013; Nurius et al., 2016; Rebbe et al., 2018; Thompson & Auslander, 2011).

This indicates that the social emotional aspects of intimate relationships are likely as important for transition age foster youth as preventative sexual health measures. These essential components of social and intimate relationships are not learned in school, and it is likely that transition age youth are lacking them- especially in group residential and non-kinship placements, without consistent adult mentors and connections. Professional clinician participants expressed confidence that youth could ask nurses any sexual health question, but eudemonic concepts did not factor into their definitions of sexual health and presumably do not for their institutions. This also places clinicians in a passive versus active role as providers. Youth cannot be depended upon to be forthcoming and may not know which questions to ask. Comprehensive sexual education that incorporates eudaemonic concepts and positive sexuality should be provided to all of these youth. While there has been substantial research regarding the high rates of early sexual debut, STI's, HIV, early pregnancy, and victimization of foster youth, there does not appear to be any research on non-preventative or eudemonic sexual health needs for this population.

Underutilization of Agency Services

The interviews made clear the normative need for continued mental and sexual health services for transition age foster youth. All participants in this project expressed disappointment that their organizations offered a variety of services, but that transition age foster youth often chose not to take advantage of these services. Professional clinician participants did not see mismatches in their mental health services, but some acknowledged gaps in their sexual health services (LGBTQ+ specific, birth control). The theme of underutilization arose organically in several interviews, and though causes were hinted at in other contexts, no one speculated why this phenomenon continued to occur. While the study of usage rates of certain mental and sexual health services by foster youth, particularly minorities, are present in the literature, the specific underuse of services does not appear to be a topic of research (McMillen & Raghavan, 2010; Oakley et al., 2018; Santos et al., 2018). While it's likely some foster youths are uninterested in certain services, mismatches between services offered and services used could also imply, as one participant suggested, "probably we could be doing more." Lack of trust in providers, related to individual or larger cultural trauma history, could be a possible cause of underuse (Oakley et al., 2018; Santos et al., 2018).

The socioeconomic and racial divides between organizational professionals providing services and youth is another potential cause. Additionally, if youth know that birth control is not available at their agency for religious reasons, those youth might be less inclined to participate or receive other services. How do youth feel about the perceived values of the organizations charged with their care? Does this impact their interaction with services and/or professionals in general? Funding for programs expanding sexual health services (where possible) may be dependent upon the number of youths requesting or using the services.

Another potential reason for underuse of services is endemic to the foster care service environment: the racial and socioeconomic divisions between professionals and foster youth. The majority of professionals foster youth interact with at foster care agencies are white and female. All the professional participants in this study working with foster youth in a therapeutic context are white and all described themselves as a "6" or greater on the MacArthur Scale of Socioeconomic Status. The sole participant of color was the only participant to discuss race and class directly as a population specific concern for transition age foster youth. Most professional participants acknowledged the youth in their care were predominantly of color and many were poor. However, they did not discuss the interaction of race and social class with their clients' mental or sexual health needs. Nor did they discuss the interaction of race and social class with their own or institutional perceptions of what services this population needs. Regardless of causation, this theme deserves further research so resources are appropriately allocated.

Decision Making

During adolescence and the transition to independent adulthood, the brain undergoes significant changes, and the desire to experiment, combined with the influence of peer relationships and the difficulty delaying gratification contribute to greater risk taking (Inshell & Tabashneck, 2022; McCormick & Telzer, 2017). Risk taking is inseparable from the process of decision making. Decision making emerged in participant interviews indirectly as a normative sexual and mental health need from discussions of trauma, consent, healthy relationships and safety. The ability to make good decisions is a significant part of sexual health and wellness, with significant implications beyond these areas for youth aging out of foster care, particularly housing, employment and safety. One participant made this connection, as well as the link between foster youths' need for healthy relationships and decision making. Multiple participants

noted that in searching for connection, foster youth frequently make poor decisions around sexual behavior. Early sexual debut, early and/or unintended pregnancy and increased rates of STI's in adolescent foster youth are well documented known risks (Blanks & Yates, 2015; Kang-Yi & Adams, 2015; McCarty et al., 2013).

Like consent, decision making is not a traditional part of sexual education, though it may be mentioned in discussions of reproductive or preventative sexual health. Preventative sexual health services exist to support sexual decision making in this population. But the question remains, how do we know youth have the proper tools to make good decisions, especially in the absence of consistent adult support? Two participants implied decision making in comments about use of technology in sexual relationships and in youths' fears and/or apprehension about life after aging out. It may be forgotten sometimes that the majority of foster youth, like their same age peers, have a desire to make positive choices in relationships and in life. Perhaps by focusing on impulsivity and risky behavior at this age in this population, we forget that youth have concerns about their ability to successfully age out to independence. These concerns are valid and decision making is a crucial part of these youths' sexual and mental health.

Preventative versus Eudemonic Sexual Health

For youth aging out of foster care, the topics of consent, decision making, healthy relationships and sexual responsibility are essential components of sexual health. Knowledge and understanding of sexual pleasure were not acknowledged by the majority of participants as a sexual health need. Only one participant independently mentioned sexual pleasure as a component of sexual health. Organizations focus on reducing the risks of HIV, STI's and early pregnancy is understandable, and these services are state mandated. Professional participants

expressed a desire to provide their foster youth clients with more comprehensive sexual health care and information. They also almost uniformly viewed these conversations as beyond their professional scope and the constraints of time.

Known Risks versus Potential

The adolescence and young adulthood of transition age foster youth is viewed generally as a minefield of various risks. Those risks are real and very serious. However, in taking this pessimistic view, the potential for youths' adaptive flexibility and ability to learn is likely underestimated (McCormick & Telzer, 2017). Would it be possible to simultaneously plan for these youths' social emotional success by providing them with the tools and skills to have healthy intimate relationships when they leave care? Many of these youth lack any family support other adolescents have in the often-bumpy transition to young adulthood. Looking past the known risks, what essential modelling, skills and mentoring do parents and/or adult connections provide to non-foster youth? Besides skills for self-sufficiency in adulthood, transition age foster youth need and deserve the skills to have healthy, rewarding and joyous intimate relationships. It should be possible to minimize their sexual health risks while preparing them to have full lives where healthy relationships support their mental health and reduce the burden of trauma. Sexual pleasure, consent, ethical behavior in relationships are all key components of a eudaemonic understanding of sexuality.

Program Rationale

Foster youth who have aged out of care or have been emancipated from care are understood to be particularly vulnerable as adults in nearly all areas of life, socioeconomically, psychologically, and physically compared to the general population (McCarty et al., 2013; Rebbe et al., 2018). Despite this vulnerability, foster youth have not been the subject of significant health research.

Researchers have suggested that the accumulation of varied adverse childhood experiences (ACE's) including poverty, neglect, physical and/or sexual abuse, family removal, failed family placements, and lack of supportive caregivers have a "dose response" relationship with adult health outcomes among previous foster youth (McCarty et al., 2013; Rebbe et al., 2018). Obesity, drug use, depression and post-traumatic stress disorder occur disproportionally in this population, but sexual health risks are also great. The connection between ACE accumulation and increased sexual risk in adulthood may perhaps be explained by maladaptive attachment in childhood: the instability of multiple foster placements and failed caregiver relationships may negatively impact children's ability to form relationships and/or make meaningful connections (McCarty et al., 2013). Foster youth typically have a younger sexual debut, more partners, higher reports of having sex for drugs or money, and higher rates of sexually transmitted infections (STI's) (Blanks & Yates, 2016; Kang-Yi & Adams, 2015; McCarty et al., 2013). New York City's greatest increase in new diagnoses of both chlamydia and gonorrhea in 2020 was in males and females aged 15-24, predominantly non-Hispanic Black (NYSDOH, 2020). Unfortunately, the age at which foster youth may be emancipated or age out of care and lack adult support is also the age at which sexual risk may peak (McCarty et al.,

2013). Part of addressing this population's increased sexual and mental health risk in New York City is understanding more clearly what their specific needs are.

Readiness

This paper is intended to generate recommendations and ideas for further research that organizations may choose to accept or take internally to increase their service and engagement with foster youth age 15 to 21 in New York City and surrounding areas.

Participants in this study and their organizations show readiness to meet and adapt to the mental health needs of transition age foster youth, and their current mental health services can be described as stable. Both agencies provide trauma focused therapy with practitioners trained in trauma focused care, and each youth has a team coordinating their care across different providers which enables more effective collaboration among specialties. What remains unclear is whether mental health providers at foster care agencies feel prepared to engage in more active and direct conversations with foster youth about sexual health topics as they relate to eudaemonic sexuality. This indicates there is only Vague Awareness of this need professionally and institutionally (Royce, et al., 2016).

Efforts to address LBGTQ+ youths' high level of need is present and increasing as is the understanding that LGBTQ+ youth are overrepresented in the NYC foster population. there is less progress towards meeting their sexual health needs. One participant initiated a new program to provide additional LGBTQ+ specific training for care team members and programming for LGBTQ+ identifying youth at their agency. This program has expanded in the time since this participant was interviewed. However, the same participant noted comprehensive sexual health

care for LGBTQ+ identifying youth was not possible at their organization due to the institutional prohibition of birth control.

It is also possible that transition age youth who are not actively engaged with these organizations may be unaware of the services they offer. Continued and improved outreach and engagement with foster youth in this age group through peers and social media is necessary.

Recommendations/Future Directions

The participant interviews reveal several areas where organizations could improve services to better serve the sexual and mental health needs of the transition age foster youth population in New York City. A priority would be incorporating a eudemonic understanding of sexuality into current preventative sexual health services. Incorporating these concepts into their definition of sexual health would better prepare youth to make decisions enabling them to engage in healthy intimate relationships- relationships that have the potential to lessen the burden of accumulated trauma. Several other recommendations arose through discussion with participants.

- Caregivers and agency employees require better training on speaking to youth about sexual health and wellness, especially for LGBTQ+ identifying youth.
- More opportunities for transition age youth to interact with peers casually in person, in their preferred setting.
- Dedicated spaces for LGBTQ+ youth to meet.
- More training for youth on basic life skills needed for independent adulthood, especially in residential settings.
- Improved follow up on and connection to mental health services post transition.

In the absence of strong, consistent family relationships in this transitional period, foster youth would clearly benefit from mentorship and advocacy from a trusted adult as well as a

sense of community with other youth aging out or who have already aged out. Ideally, each youth aging out would have their own mentor/advocate to help support them emotionally and these individuals could be trained to approach sexual health from a eudemonic perspective.

In 2019, a coalition of organizations, advocates, and individuals in child welfare established the Fair Futures program at all city foster care agencies, a "first in the nation, long-term, comprehensive support system for foster youth," that has continued underfunded but holds significant promise (Administration for Children and Family Services Strategic Blueprint, 2021; Council of the City of New York, 2022; Fair Futures, n.d.). The focus of Fair Futures is on coaching, education, employment, housing and permanency outcomes for youth age 11 to 21 (Administration for Children and Family Services Strategic Blueprint, 2021; Fair Futures, n.d.). If Fair Futures continues and expands, perhaps it is possible the program could better support youth's sexual health as well. New York also receives funding for Independent Living Programs and other services for transition age youth through Federal Title IV-E, also known as the John H. Chafee Foster Care Independence Program (U.S. Department of Health and Human Services, 2012). The funding for these programs often changes and they also focus on education and training (Council of the City of New York, 2022; National Council of Juvenile and Family Court Judges, 2002).

In 2021, the Annie E. Casey Foundation proposed the S.O.U.L (Support, Opportunity, Unity, Legal Relationship) Family: a new legal transition pathway to permanency that allows transition age youth to define their own family or network of caring adults to support them in adulthood (Annie E. Casey Foundation, 2021). This proposal recognizes that the three traditional legal options, reunification, adoption, and guardianship, are not foster youth directed. Nor do the current permanency options necessarily reflect social, cultural and individual definitions of

enduring loving and supportive relationships (Annie E. Casey Foundation, 2021). Failing to achieve “permanency” through available pathways is traumatic for youth aging out; and it happens to over 20,000 foster youth 16 and older per year, but disproportionately to Black and Hispanic youth (Annie E. Casey Foundation, 2021). The S.O.U.L. pathway offers youth another route to “succeed” upon transition, on their own terms.

The limitations of this project suggest a number of potential directions for future research. Clearly, the perspectives of transition age youth themselves on their sexual and mental health needs should be investigated. Speaking with transition age youth directly was beyond the scope of this project. Also, the number of professional participants in the current project was significantly impacted by the COVID-19 pandemic and outreach- it would be valuable to speak with more mental health professionals, as well as medical professionals and non-professionals in roles serving this population. Conducting qualitative research with kinship and non-kinship caregivers may provide insight into how well prepared they feel to discuss eudemonic sexual health. There is little to no research about the impact of trauma and/or failed attachment on the adult relationships of former foster youth. Further research about this topic should seek direct engagement of foster youth to express their sexual and mental health needs, in a setting that prioritizes their comfort, whether with peers in focus groups or one on one interviews.

New York has acknowledged the deep impact of social determinants of health on referrals to foster care and has pledged to focus more efforts and funding on preventative family services to reduce the number of children entering foster care at any age (Hochul & Poole, 2022). However, the status quo for transition age youth leaving care without reunification, adoption or guardianship fails to meet this population’s burden of needs. The problem is monumental and solutions are neither obvious nor close at hand. Funding is needed for new interventions, but that

is not all. New ideas and approaches are clearly needed to support the futures of the vulnerable youth transitioning out of care.

Dissemination Plan

This project has been undertaken as a requirement for completion of a master's degree in Health Advocacy at Sarah Lawrence College in New Rochelle, New York. A copy of the paper will remain at the Sarah Lawrence College Library. Interview participants will receive a digital copy of this paper. External stakeholders in foster care agencies or elsewhere will have access to my findings and recommendations based on their interest. Additionally, my report and findings may be shared with my former partner organization Community Healthcare Network to further their important work with young adults in New York City.

References

Administration for Children and Family Services NYC. (2021). *FY 2021 foster care strategic blueprint: Status report*. https://www1.nyc.gov/site/acs/about/fcstrategicblueprint.page

Annie E. Casey Foundation. (2022). *Kids Count Data Center: Out of home placement*. https://datacenter.kidscount.org/data#USA/2/35/38,40/char/0

Annie E. Casey Foundation. (2021). *Soul Family: Support, opportunity, unity, legal partnership: A proposed legal permanency option for older youth in foster care*. https://www.aecf.org/blog/soul-family-permanency-option-for-older-youth-in-foster-care

Baams, L., Wilson, B.D., & Russell, S.T. (2019). LGBTQ youth in unstable housing and foster care. *Pediatrics*, *143*(3), Article e20174211.

Blanks, A.G. & Yates, T.M. (2016). Sexual risk taking among recently emancipated female foster youth: sexual trauma and failed family reunification experiences. *Journal of Research On Adolescence, 26*(4), 819-829.

Courtenay, M.E. & Hughes, D. (2005). The transition to adulthood for youth "aging out" of the foster care system. In Osgood et al. (Eds.), *On your own without a net: The transition to adulthood for vulnerable populations*. The University of Chicago Press.

Curry, S.R. & Abrams, L.S. (2014). Housing and social support for youth aging out of foster care: state of the research literature and directions for future inquiry. *Child Adolescent Social Work Journal*, *32*, 143-153.

Fair Futures New York. (n.d.). *Mission*. https://www.fairfuturesny.org/

Hedenstrom, M. A. (2014) *Aging out of foster care: The experiences of former foster youth who successfully navigated this transition*. [Doctoral dissertation, Georgia State University]. Scholar Works @ Georgia State University. https://scholarworks.gsu.edu/nursing_diss/38/

Hochul, K. & Poole, S. J. (2022). *New York State Families First Prevention Services Act: Prevention plan*. https://ocfs.ny.gov/main/sppd/docs/FFPSA-Prevention-Plan-2022Feb23.pdf

Inshell, C. & Tabashneck, S., Shen, F.X., Edersheim, J.G. & Kinscherff, R.H. (2022). *White paper on the science of late adolescence: A guide for attorneys, judges and policymakers*. Center for Law, Brain and Behavior at Massachusetts General Hospital. https://clbb.mgh.harvard.edu/wp-content/uploads/CLBB-White-Paper-on-the-Science-of-Late-Adolescence-3.pdf

Kang-Yi, C.D. & Adams, D.R. (2015). Youth with behavioral health disorders aging out of foster care: a systematic review and implications for policy, research and practice. *Journal of Behavioral Health Services and Research*, 25-51.

Kusunoki, Y., & Barber, J. S. (2020). The dynamics of intimate relationships and contraceptive use during early emerging adulthood. *Demography*, *57*(6), 2003–2034. https://doi.org/10.1007/s13524-020-00916-1

Lewis, L. J. (2004). Examining sexual health discourses in a racial/ethnic context. *Archives of Sexual Behavior*, *33*(3), 223-234.

Lim, S., Singh, T., & Gwynn, C.R. (2017). Impact of a supportive housing program on housing stability and sexually transmitted infections among young adults in New York City aging out of foster care. *American Journal of Epidemiology*, *186*(3), 297-304.

McCarty, C., Simoni, J., Dworsky, A., & Courtney, M.E. (2013). Psychosocial pathways to sexually transmitted infection (STI) risk among youth transitioning out of foster care: Evidence from a longitudinal cohort study. *Journal of Adolescent Health*, *53*(4), 478-485.

McCormick, E. M., & Telzer, E. H. (2017). Adaptive adolescent flexibility: Neurodevelopment of decision-making and learning in a risky context. *Journal of Cognitive Neuroscience*, *29*(3), 413–423. https://doi.org/10.1162/jocn_a_01061

McMillen, J.C. & Raghavan, R. (2010). Pediatric to adult mental health service use of young people leaving the foster care system. *Journal of Adolescent Health*, *44*(1), 7-13.

National Council of Juvenile and Family Court Judges. (2002). *The Foster Care Independence Act of 1999 and the John H. Chafee Foster Care Independence Program*. https://www.ncjfcj.org/publications/the-foster-care-independence-act-of-1999-and-the-john-h-chafee-foster-care-independence-program/

New York State Department of Health. (2017). *Sexually transmitted infections surveillance report: 2018*. https://www.health.ny.gov/statistics/diseases/communicable/std/docs/sti_surveillance_report_2017.pdf

Nurius, P.S., Prince, D.M., & Rocha A. (2016). Cumulative disadvantage and youth well-being: A multi-domain examination with life course implications. *Child Adolescent Social Work Journal*, *32*(6), 567–576.

Oakley, L.P., Harvey, S.M., & Lopez-Cevallos, D.F. (2018). Racial and ethnic discrimination: medical mistrust and satisfaction with birth control services among young adult Latinas. *Women's Health Journal*, *28*(4), 313-320.

Office of Children and Family Services. (2018). *OCFS 2018 monitoring and analysis profiles with select date 2014 to 2018*. https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20City.pdf

Office of Children and Family Services. (2019). *Number of children in care and custody by county and agency 2019 Q3*. https://ocfs.ny.gov/main/sppd/docs/ffpsa-reports/2019-Q3-Care-and-Custody-by-Setting-Type.pdf

Rebbe, R., Nurius, P.S., Courtney, M.E., & Ahrens, K.R. (2018). Adverse childhood experiences and young adult health outcomes for youth aging out of foster care. *Academic Pediatrics*, *18*(5), 502-509.

Royse, D., Thyer, B.A. & Padgett, D.K. (2016). Needs assessment. In *Program evaluation: An introduction to an evidence-based approach* (6th ed,, pp. 63-91) Cengage Learning.

Sandfort, T.G. (2021). *Experiences and well-being of gender diverse youth in foster care in New York City: Disproportionality and disparities*. Columbia University. https://www1.nyc.gov/assets/acs/pdf/about/2020/WellBeingStudyLGBTQ.pdf

Santa Maria, D., Rafferty, J., Lau, M., Guilamo-Ramos, V., Tebb, K., Chadi, N., Ambresin, AE., Vyver, E. & Marcell, A.V. (2018). Advocating for adolescent and young adult male sexual and reproductive health: A position statement from the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*, 63, 657-661.

Santos, C.A., Williams, E.C., Rodriguez, J. & Ornelas, I.J. (2017). Sexual health in a social and cultural context: A qualitative study of young Latina lesbian, queer and bisexual women. *Journal of Racial Ethnic Health Disparities*, *4*(6), 1206-1213. http://doi:10.1007/s40615-016-0327-8

The Council of the City of New York. (2021). *Report on the Finance Division on the fiscal 2022 plan for the Administration of Children's Services*. https://council.nyc.gov/budget/wp-content/uploads/sites/54/2021/03/ACS.pdf

Thompson, Jr., R.G. & Auslander, W.F. (2011). Substance use and mental health problems as predictors of HIV sexual risk behaviors of adolescents in foster care. *Health & Social Work*, *36*(1), 33-43.

Transition age youth in foster care in New York. (2017). https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_New-York.pdf

U.S. Department of Health and Human Services. (2012). *The John H. Chaffee Foster Youth Independence Program*. https://www.acf.hhs.gov/cb/grant-funding/john-h-chafee-foster-care-independence-program

Appendix A

Sarah Lawrence College Research Participant Consent Form

SARAH • LAWRENCE • COLLEGE

Mental and sexual health needs assessment of transition age foster youth (age 18-24 years) in the New York City metropolitan area.

I am (we are) asking you to take part in a research study at Sarah Lawrence College. Please read through the following questions and responses and ***ask any other questions*** that will help you to decide whether or not to participate.

What is the purpose of this study?

My project seeks to identify and describe the perceived mental and sexual health needs of transition age foster youth/young adults aged 18-24 in the New York City metropolitan area. This needs assessment will be conducted through semi-structured interviews and surveys with social workers, psychologists, physicians, milieu workers and others who have direct working relationships with the target population.

Why am I being asked to participate?

You are asked to participate if you have direct working relationships with foster youth/young adults aged 18-24 in New York City.

What will I be asked to do?

Individuals will be asked to participate in one semi-structured interview approximately sixty minutes in length. They will also be asked to complete a brief demographic survey. Interviews will be audio and video recorded and transcribed for research purposes only. Consent to recording is an optional component of study participation.

Is my participation voluntary?

Participation is entirely voluntary. Non participation will have no effect on individuals' relationship with Sarah Lawrence College. Participants are not required to answer any questions.

Are there any benefits or risks associated with my participation in this study?

There are no benefits associated with participation. There is minimal risk.

Will I be compensated for my participation?

Participants will not be compensated.

Will the information I provide be kept confidential?

Participants will not be identified in any written or oral report of the research study. Only the researcher will have access to the information and it will be stored securely.

If I have any questions or concerns after the study, how can I contact you?

Elizabeth Claessens
eclaessens@gm.slc.edu

Linwood Lewis (Faculty Advisor)
ljlewis@sarahlawrence.edu

Who can I contact if I have questions about my rights as a research participant?

The IRB co-chairs Professors Elizabeth Johnston (203-722-3287) and Claire Davis (914-395-2605) at irb@sarahlawrence.edu.

Please indicate with your signature on the space below that you understand your rights and voluntarily agree to participate in the study.

______________________________ ______________________
Signature of Participant Date

____
Print Participant Name

____ _____________________
Elizabeth Claessens, Investigator Date

Please indicate with your signature on the space below that you understand your rights and voluntarily agree to have your participation in this study audio- and/or video-recorded.

______________________________ ______________________
Signature of Participant Date

Appendix B

Participant Demographic Survey

Sarah Lawrence College
Health Advocacy Graduate Program
Research: Assessment of Mental and Sexual Health Needs of NYC Foster Youth/Young Adults

Demographic Survey for Interview Subjects

1. What is your role at your current organization?
2. How long have you worked at your current organization?
3. How old are the (foster) individuals you typically work with? Please circle one.

   18 years or younger　　　　18 years and older

4. How long have you worked with foster youth/young adults?
5. What is your educational background? Please choose one:

   _____High school diploma or equivalency (GED)

   _____Associate degree (junior college)

   _____Bachelor's degree

   _____Master's degree

   _____Doctorate

   _____Professional (MD, JD, DDS, etc.)

   _____Other specify

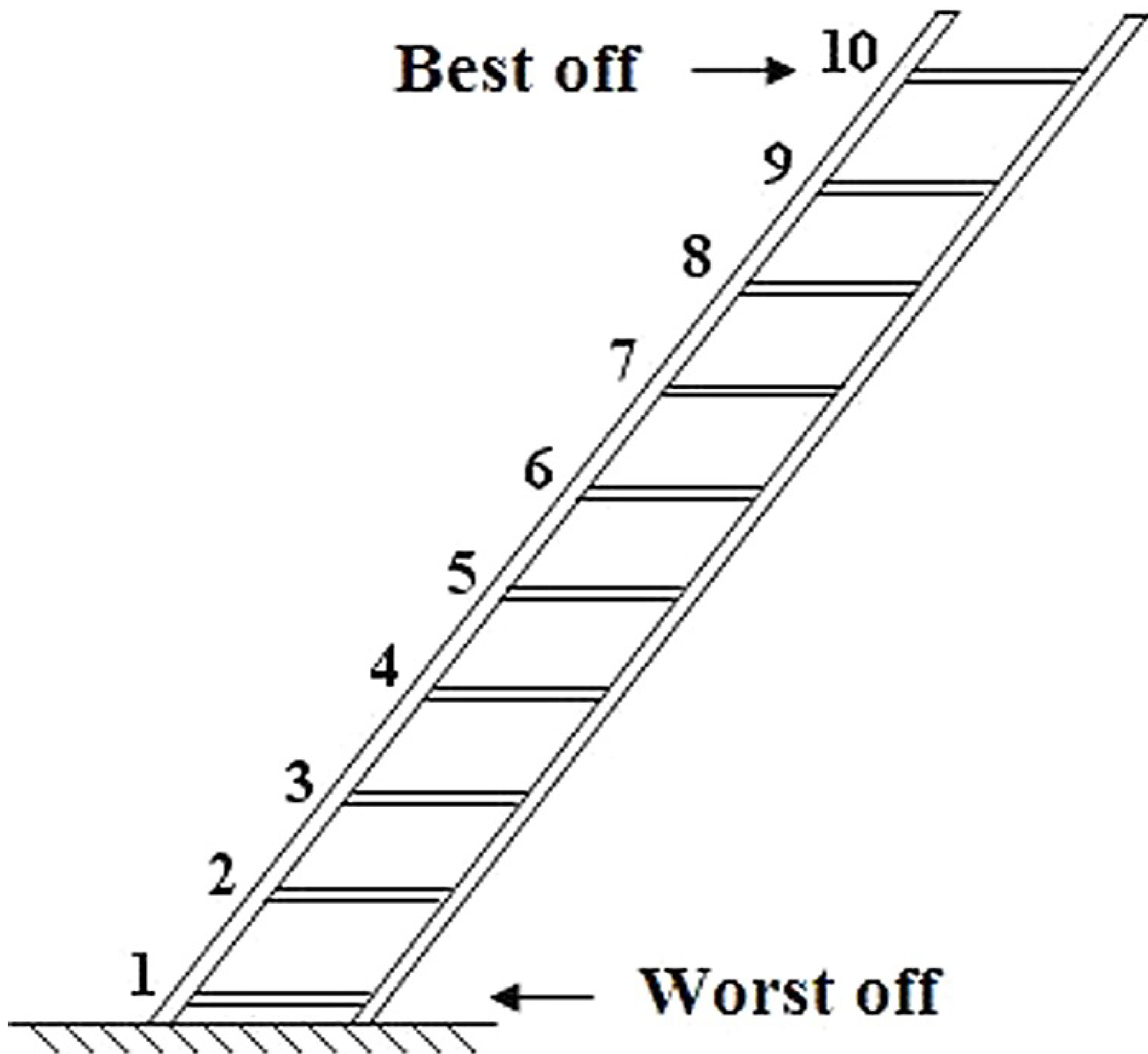
   _____None of the above (less than high school)

6. What is your race/ethnicity? (Optional)
7. What is your gender? (Optional)
8. Think of this ladder as showing where people stand in United States society.

- At the top of the ladder are the people with the highest standing.
- At the bottom are the people who have the lowest standing.

Please choose a number next to the rung of the ladder where you think you stand relative to other people in the United States.

____



(Adapted from The MacArthur Community Tool)

Appendix C

Participant Interview Questionnaire

Interview Questions for Individuals Working with or Adjacent to Transition Age Foster Youth

1. Please tell me about the work that you do for (insert organization) or with foster youth.
   - Follow up: Can you please tell me what age(s) you typically work with?
2. When you think about sexual health, what do you think that means?
   - Follow up:- How do you think patients in this age group understand sexual health?
3. In thinking about the sexual health needs of 16-21 year old's, what issues do you think are most pressing?
   - Follow up: How well do you think those needs have been met so far?
   - Follow up: Is there a discussion of sexual pleasure with this population?
   - Follow up: Is there a discussion about consent?
4. This may be a switch from our previous discussion, but I'd like to discuss mental health. How would you characterize the mental health needs of the youth that you work with?
5. How would you describe the impact of COVID-19 on this group's health needs?
   - Follow up: How have the youth you work with directly been faring?
6. What do you think are (insert organization) greatest strengths in addressing the sexual health needs of young adults?
7. What could (insert organization) do better?

- Follow up: What other services would you like to see made available to this population?

8. Is there anything about this population sexual or mental health I did not ask about but should have?