Access in Brief: Behavioral Health Services for Youth in Foster Care

Medicaid and the State Children's Health Insurance Program (CHIP) play an important role in the treatment of mental illness and substance use disorder (SUD) in children and adolescents, including those in foster care.[1] This is due to both eligibility policy, as well as high rates of behavioral health conditions among this population. Low-income children and adolescents who have been removed from their homes are automatically eligible for Medicaid on the basis of their eligibility for child welfare assistance under Title IV-E of the Social Security Act (the Act).[2] Those who are not receiving Title IV-E assistance may be eligible for Medicaid on another basis, such as having low income or a disability. Medicaid, including Medicaid-expansion CHIP, must cover medically necessary Medicaid-coverable behavioral and other health services for enrollees under age 21 as part of the early and periodic screening, diagnostic, and treatment (EPSDT) benefit, regardless of whether the services are covered in the state plan (CMS 2014).[3] In separate CHIP, behavioral health services are a required benefit (§ 2103(c)(5) of the Act).

Relative to their peers in the general population, children and youth in foster care are more likely to experience behavioral health conditions; however, several studies suggest they are not receiving needed services (MACPAC 2021, Pires et al. 2018, Turney and Wildeman 2016, SAMHSA 2013).[4,5] Lack of care when it is needed often leads to poor health outcomes. For example, children and youth in foster care are nearly four times more likely to have attempted suicide than other youth (Pilowsky and Wu 2006).

In this issue brief, we present analyses of the experience of adolescents age 12–17 who reported staying overnight in foster care in the past 12 months using data from the National Survey on Drug Use and Health (NSDUH) from 2015 to 2019.[6] Specifically, our analysis examines selected characteristics, prevalence of certain behavioral health conditions, and access to services among these youth, comparing the experience of youth with Medicaid or CHIP to that of youth with private coverage where possible.[7] We also report estimates by race, ethnicity, and sex where sample size permits.

We found that the vast majority (63.5 percent) of non-institutionalized youth age 12–17 who stayed overnight in foster care were enrolled in Medicaid or CHIP (MACPAC 2021). Many of these youth experience behavioral health conditions and receive treatment at high rates. Specifically:

- More than a quarter of these youth reported experiencing a major depressive episode (MDE) at some point in their lifetime and nearly one in five reported having an SUD in the past year.
- Access to non-specialty mental health treatment was high (100 percent) and Medicaid and CHIP beneficiaries generally received mental health services at similar rates as their peers with private coverage.
- There were no significant differences in access to mental health treatment among Medicaid and CHIP beneficiaries when examining rates by sex or race and ethnicity, though our analysis is limited due to the small sample size.
- The majority of all youth who stayed overnight in foster care, including youth covered by Medicaid or CHIP, reported being able to access SUD treatment when needed (MACPAC 2021).

NSDUH data are self-reported, and therefore may over- or underrepresent the rate at which survey respondents experience behavioral health conditions and access treatment. Individual responses are not validated using psychiatric diagnostic information (SAMHSA 2020a). They may be influenced by a variety of social and cultural factors, including beliefs and perceptions regarding mental health and SUD (Ward et al. 2013). In addition, the NSDUH does not include residents of institutional group quarters, such as congregate child care settings serving certain children in foster care.[8] Children in congregate care are almost three times as likely to have a psychiatric diagnosis compared to those in other foster care settings (ACF 2015). As such, findings from NSDUH may underestimate the prevalence of behavioral health conditions among youth who have stayed in foster care.

Characteristics of Youth Involved in Foster Care

Below, we discuss certain demographic and other characteristics, including insurance status, race and ethnicity, and changes in housing status for youth who stayed in foster care.

Demographic characteristics

Medicaid and CHIP cover nearly two-thirds of adolescents in foster care. From 2015–2019, non-institutionalized youth age 12–17 who stayed overnight in foster care in the past 12 months were significantly more likely to be enrolled in Medicaid or CHIP (63.5 percent) than private coverage (23.1 percent) (Table 1). Beneficiaries who stayed overnight in foster care were significantly less likely to be white (41.5 percent) than their peers with private coverage (60.7 percent) (MACPAC 2021).

TABLE 1. Demographic Characteristics of Non-Institutionalized Youth Age 12–17 Who Stayed Overnight in Foster Care in the Past 12 Months, 2015–2019

Demographic characteristics	Percentage of youth age 12-17		
	Total	Medicaid or CHIP	Private coverage
Total (all youth who stayed in foster care, past year)	100.0%	63.5%	23.1%*
Sex			
Male	49.5	49.7	52.4
Female	50.5	50.3	47.6
Race and ethnicity			
White, non-Hispanic	42.1	41.5	60.7*
Black, non-Hispanic	23.2	24.2	–
Hispanic	27.0	27.5	–
Asian American, non-Hispanic	–	–	–
American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander, non-Hispanic	–	–	–
Two or more races, non-Hispanic	–	–	–

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview. Youth with other insurance and those who were uninsured are not included due to the small sample size. Therefore, estimates for each coverage group do not sum to 100 percent.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

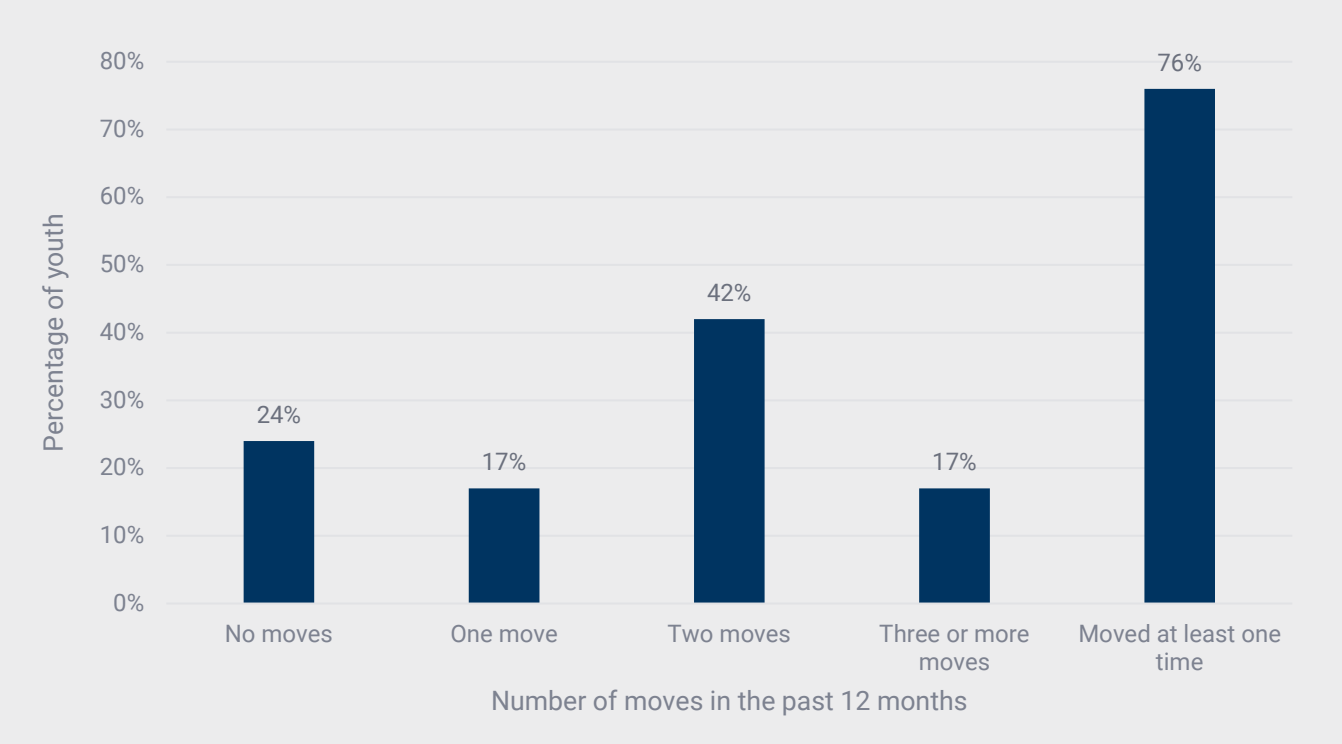
Other federal data indicate that, nationally, Black children and children of two or more races are overrepresented among the foster care population. For example, in fiscal year 2019, Black children represented 23 percent of all children in foster care but only 13 percent of the total child population. Children of two or more races accounted for 8 percent of the foster care population but only 5 percent of all children (ACF 2020, KFF 2021).[9]

Housing stability

Multiple residential moves have been associated with negative health outcomes in children.[10] Children who move frequently are more likely to have poor overall physical health and chronic health conditions (Webb et al. 2016, Busacker and Kasehagen 2012). Those who experienced multiple moves as children are also more likely to report lower life satisfaction and psychological well-being in adulthood (Oishi and Schimmack 2010).

Multiple residential moves are common among youth involved in foster care. From 2015–2019, more than three-quarters (76 percent) of non-institutionalized youth age 12–17 covered by Medicaid or CHIP who stayed overnight in foster care reported moving at least one time in the past 12 months and 17 percent reported three or more moves (Figure 1) (MACPAC 2021).[11]

FIGURE 1. Change in Housing Status of Non-Institutionalized Youth Age 12–17 Covered by Medicaid or CHIP Who Stayed Overnight in Foster Care in the Past 12 Months, 2015–2019



Notes: Due to issues with sample size, we were unable to produce estimates for changes in housing status among youth with private coverage.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

Prevalence of Selected Behavioral Health Conditions

For adolescent respondents, the NSDUH captures prevalence of mental illness in two categories:

- Major depressive episode—This category includes adolescents who reported experiencing certain symptoms nearly every day in the same two-week period at any point in their life. Adolescents were defined as having an MDE in the past year if they had a lifetime MDE, felt depressed or lost interest or pleasure in daily activities for 2 weeks or longer in the past 12 months, and experienced during that time some of the symptoms they reported for a lifetime MDE.[12]
- MDE with severe role impairment—This category includes adolescents who reported impairment caused by an MDE in the past 12 months. Severe impairment was defined by the level of problems reported in four major life activities or role domains: (1) ability to do chores at home; (2) ability to do well at school or work; (3) ability to get along with family; and (4) ability to have a social life.[13,14]

Major depressive episodes

From 2015–2019, more than a quarter (25.4 percent) of non-institutionalized youth age 12–17 who stayed overnight in foster care reported experiencing an MDE at some point in their lifetime and approximately one in five (21.9 percent) reported an MDE in the past year (Table 2).[15] Among youth covered by Medicaid or CHIP who stayed overnight in foster care, nearly one in five (19.6 percent) reported experiencing an MDE in their lifetime and 12.6 percent reported experiencing an MDE with severe role impairment (MACPAC 2021).[16]

TABLE 2. Major Depressive Episodes among Non-Institutionalized Youth Age 12–17 Who Stayed Overnight in Foster Care in the Past Year, 2015–2019

Type of condition	Percentage of youth age 12–17		
	Total	Medicaid or CHIP	Private coverage
Lifetime MDE	25.4%	19.6%	–
MDE in past year	21.9	17.5	–
MDE with severe role impairment	15.9	12.6	–

Notes: MDE is major depressive episode. The 2019 National Survey on Drug Use and Health (NSDUH) used criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* to identify major depressive episodes. Questions from the Sheehan Disability Scale determined if a major depressive episode caused severe role impairment by creating major problems with the ability to do chores at home, do well at work or school, get along with family, or have a social life.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview. Youth with other insurance and those who were uninsured are not included due to the small sample size. Therefore, estimates for each coverage group do not sum to 100 percent.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

Suicidal thoughts and behaviors

Among non-institutionalized youth age 12–17 who stayed overnight in foster care between 2015, roughly one in five (20.2 percent) reported thoughts of suicide, 17.9 percent reported having plans of suicide, and 15.4 percent reported attempting suicide in the past year. Among youth covered by Medicaid or CHIP who stayed overnight in foster care, 17.6 percent reported thoughts of suicide, 14.5 percent reported having plans of suicide, and 11.7 percent reported attempting suicide (MACPAC 2021).[17]

Substance use

From 2015–2019, nearly one in five (19.1 percent) non-institutionalized youth age 12–17 who stayed overnight in foster care had an SUD in the past 12 months.[18] The prevalence of SUD did not vary significantly between youth enrolled in Medicaid or CHIP (17.8 percent) and those with private coverage (24.5 percent) (MACPAC 2021).[19]

Use of Behavioral Health Care

For adolescent respondents, the NSDUH captures treatment for emotional and behavioral health problems unrelated to substance use, as well as use of services for SUD.

Mental health treatment

Youth who stayed overnight in foster care reported high rates of mental health treatment. From 2015–2019, all such youth reported receiving non-specialty mental health services and 82.2 percent reported receiving specialty mental health care (Table 3).[20] Youth covered by Medicaid or CHIP and those with private coverage reported receiving treatment at similar rates. Nearly half of beneficiaries reported staying overnight in a hospital (48.3 percent) or residential treatment center (45.1 percent) (MACPAC 2021).

TABLE 3. Mental Health Treatment among Non-Institutionalized Youth Age 12–17 Who Stayed Overnight in Foster Care in the Past 12 Months, 2015–2019

Treatment characteristics	Percentage of youth age 12–17		
	Total	Medicaid or CHIP	Private coverage
Received non-specialty mental health services	100.0%	100.0%	100.0%
Received specialty mental health services	82.2	79.5	81.1
Received specialty inpatient mental health services	59.7	55.6	63.6
Received specialty outpatient mental health services	67.6	63.6	67.3
Stayed overnight in a hospital	50.2	48.3	47.2
Stayed overnight in a residential center for emotional treatment	49.5	45.1	58.6
Spent time in a day treatment program	41.6	38.5	45.1
Received specialty treatment from a private therapist, psychologist, psychiatrist, social worker, or counselor	40.3	38.2	40.7
Received specialty treatment from an in-home therapist, counselor, or family preservation worker	35.3	30.5	35.8
Received specialty treatment from a family doctor or pediatrician	25.2	26.2	25.6

Notes: The 2019 National Survey on Drug Use and Health defined specialty mental health services as treatment or counseling for emotional or behavioral problems provided in outpatient, inpatient, or residential mental health settings. Outpatient settings include: (1) private therapists, psychologists, psychiatrists, social workers, or counselors; (2) mental health clinics or centers; (3) partial day hospitals or day treatment programs; and (4) in-home therapists, counselors, or family preservation workers. Inpatient settings include hospitals and residential treatment centers. Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview. Youth with other insurance and those who were uninsured are not included due to the small sample size. Therefore, estimates for each coverage group do not sum to 100 percent.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

Reported use of mental health treatment among Medicaid and CHIP beneficiaries who stayed overnight in foster care did not vary across racial and ethnic groups, though estimates are limited due to the small sample size (Table 4). Similarly, we did not observe significant differences in access to mental health treatment when comparing the experience of male and female beneficiaries who stayed overnight in foster care (Table A-1).

TABLE 4. Mental Health Treatment among Non-Institutionalized Youth Age 12–17 Enrolled in Medicaid or CHIP Who Stayed Overnight in Foster Care in the Past 12 Months, by Race and Ethnicity, 2015–2019

Treatment characteristics	Percentage of youth age 12–17				
	White	Black	Hispanic	AIAN and NHPI	Two or more races
Received non-specialty mental health services	100.0%	100.0%	100%	100.0%	100.0%
Received specialty mental health services	77.7	79.8	79.1	92.1	88.9
Received specialty inpatient mental health services	62.8	53.6	44.9	87.1	59.7
Received specialty outpatient mental health services	68.1	60.2	61	49.7	56.1
Stayed overnight in a hospital	54.2	46.5	42.0	50.6	–
Stayed overnight in a residential center for emotional treatment	53.1	34.4	40.7	–	59.7
Spent time in a day treatment program	48.4	28.8	–	–	–
Received specialty treatment from a private therapist, psychologist, psychiatrist, social worker, or counselor	44.9	36.1	–	–	–
Received specialty treatment from an in-home therapist, counselor, or family preservation worker	32.9	36.9	–	–	–
Received specialty treatment from a family doctor or pediatrician	24.0	36.2	–	–	–

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, and two or more races do not include respondents of Hispanic origin. Estimates for Asian Americans are not included due to the small sample size.

The 2019 National Survey on Drug Use and Health defined specialty mental health services as treatment or counseling for emotional or behavioral problems provided in outpatient, inpatient, or residential mental health settings. Outpatient settings include: (1) private therapists, psychologists, psychiatrists, social workers, or counselors; (2) mental health clinics or centers; (3) partial day hospitals or

day treatment programs; and (4) in-home therapists, counselors, or family preservation workers. Inpatient settings include hospitals and residential treatment centers. Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

School-based mental health services

From 2015–2019, 41.6 percent of youth who stayed overnight in foster care reported receiving mental health services from education sources such as a school social worker or school psychologist (Table 5). Youth covered by Medicaid or CHIP and those with private insurance reported accessing school-based mental health services at similar rates (MACPAC 2021).

TABLE 5. School-Based Mental Health Services among Non-Institutionalized Youth Age 12–17 Who Stayed Overnight in Foster Care in the Past Year, 2015–2019

Treatment characteristics	Percentage of youth age 12–17		
	Total	Medicaid or CHIP	Private coverage
Received mental health services from education resources	41.6%	35.8%	45.2%
Received specialty treatment in a school or school program for emotional problems	29.9	28.1	35.7
Talked to a school social worker, psychologist, or counselor for emotional problems	31.2	28.1	–

Notes: The 2019 National Survey on Drug Use and Health defined mental health services from education resources as having talked to a school social worker, school psychologists, or school counselors and/or having attended a special school or participated in a special program at a regular school for problems with behavioral or emotions that were not caused by alcohol or drugs.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview. Youth with other insurance and those who were uninsured are not included due to the small sample size. Therefore, estimates for each coverage group do not sum to 100 percent.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.

Our ability to analyze the use of school-based mental health services by race, ethnicity, and sex is limited due to the small sample size. However, where data are available, they show that white, Black, and Hispanic youth covered by Medicaid or CHIP who stayed overnight in foster care reported receiving mental health services from education sources at similar rates. Male and female beneficiaries who stayed overnight in foster care also reported similar use of mental health services from education sources (MACPAC 2021).

Substance use treatment

From 2015–2019, 14.8 percent of youth who stayed overnight in foster care and 12.3 percent of youth who stayed in foster care and were enrolled in Medicaid or CHIP reported needing but not receiving illicit drug or alcohol treatment in the past year. However, only 11.5 percent of youth who stayed overnight in foster care

and were enrolled in Medicaid or CHIP reported receiving any substance use treatment in the past year and 13.9 percent reported ever receiving alcohol or drug treatment (MACPAC 2021).[21]

Data and Methods

Data sources

Data for this report comes from the 2015–2019 NSDUH, an annual survey sponsored by the Substance Abuse and Mental Health Services Administration, that conducts interviews with approximately 70,000 randomly selected, civilian, non-institutionalized individuals age 12 and older in the United States. NSDUH respondents are residents of households and individuals in non-institutional group quarters, such as shelters, rooming houses, college dorms, and halfway houses. Individuals with no fixed household address, such as individuals who are homeless and not in shelters; active-duty military personnel; and residents of institutional group quarters, including congregate settings for youth in foster care, correctional facilities, nursing homes, and mental institutions, are excluded. The NSUDH is a primary source of national and state-level estimates on use of tobacco products, alcohol, illicit drugs, SUDs, mental health status, and related treatment (SAMHSA 2020b).

Insurance coverage

The following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare; private; Medicaid/CHIP; other type of insurance (e.g., TRICARE, military health care); or uninsured. Coverage source is defined as primary coverage at the time of the interview. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care. For individuals 12–17, the NSDUH accepts proxy responses from household members identified as being better able to give accurate information about health insurance (SAMHSA 2020b).

Point estimates were calculated using sample weights, and corresponding variances accounted for the complex sample design of NSUDH. All estimates in this brief have a relative standard error of less than or equal to 30 percent. All differences discussed were computed using t-tests and are significant at the 0.05 level.

Endnotes

[1] Foster care settings include foster family homes and child care institutions caring for children who are under supervision of the state because they have experienced abuse or neglect (ACF 2021). In FY 2019, the majority of children and adolescents in foster care (82 percent) lived in family homes (nonrelative or relative foster family homes and pre-adoptive homes), 10 percent lived in a group home or institution, about 7 percent were on trial home visits or in supervised independent living, and close to 1 percent had run away (ACF 2020).

[2] Under Title IV-E of the Act, states, territories, and tribes may claim partial federal reimbursement for the cost of providing foster care, adoption assistance, and guardianship assistance to children who meet federal eligibility rules. The Family First Prevention Services Act (P.L. 115-123) expanded the allowable uses of Title IV-E funds to include certain foster care prevention services and kinship navigator programs (i.e., information, referral, and follow-up services to grandparents and other relatives serving as guardians) (CRS 2021).

[3] Federal Medicaid or CHIP requirements, including Medicaid's EPSDT benefit, are intended to ensure access to behavioral health services for children and youth.

[4] MACPAC's June 2021 chapter on access to behavioral health services for children and adolescents covered by Medicaid and CHIP used the 2018 NSDUH to estimate the prevalence of behavioral health conditions among non-institutionalized adolescents age 12–17 and the rates at which they receive treatment (MACPAC 2021).

[5] In 2011, children and adolescents in foster care represented 2.6 percent of the Medicaid and CHIP child population, yet constituted 11.1 percent of the child and adolescent population using behavioral health services (Pires et al. 2018).

[6] Youth who reported staying overnight in foster care include youth who responded that they had stayed overnight or longer in foster care or in a therapeutic foster care home because they had emotional or behavioral problems that were not caused by alcohol or drugs (SAMHSA 2020c).

[7] Other non-institutionalized adolescents age 12–17 who stayed in foster care in the past 12 months reported being uninsured or receiving other types of health insurance, defined as coverage through the Veterans Administration or other military program, with no Medicare, Medicaid, or private insurance. These estimates are not reported due to the small sample size (MACPAC 2021).

[8] Congregate care is defined as a group home (a licensed or approved home providing 24-hour care in a small group setting) or institution (a licensed or approved child care facility operated by a public or private agency providing 24-hour care or treatment typically for 12 or more children). These settings include child care institutions, residential treatment facilities, and maternity homes (ACF 2015).

[9] Preliminary FY 2019 data from the Adoption and Foster Care Analysis and Reporting System include the percentage of children in foster care by race and ethnicity (ACF 2020). These data are compared to estimates of the population distribution of children by race and ethnicity from an analysis of the 2019 American Community Survey (KFF 2021).

[10] The number of residential moves that an individual experiences in a given period (e.g., the past year or childhood) is often used as a measure of housing stability. However, there is no standard definition of multiple residential moves. Researchers have examined various metrics such as six or more moves during childhood, three or more moves during childhood, and more than one move in a year (Leopold et al. 2016).

[11] Due to the small sample size, we are unable to estimate the number of moves in the past 12 months for youth with private insurance who stayed in foster care (MACPAC 2021).

[12] The NSDUH defined individuals as having had a lifetime MDE if they reported at least five or more of the following symptoms in the same two-week period during their lifetime (with at least one of the symptoms being a depressed mood or loss of interest or pleasure in daily activities): (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation at a level that is observable by others nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death or recurrent suicidal ideation (SAMHSA 2020a).

[13] For adolescent respondents, the NSDUH collects data on impairment caused by MDE using the Sheehan Disability Scale, a measure of impairment due to mental health issues in four major life activities or role domains. Each section consists of four questions, and each item uses an 11-point scale ranging from 0 (no problems) to 10 (very severe problems). Ratings of seven or greater for problems in one or more role domains were classified as severe impairment (SAMHSA 2020a).

[14] The NSDUH examines prevalence rates for MDE and MDE with severe role impairment among adolescents. Because it does not provide data on psychiatric diagnoses, it may not reflect important trends in the prevalence of certain mental health conditions among adolescents, including those who stayed overnight in foster care. Other federal data sources, using parental reports of their child's diagnoses, find that attention-deficit/hyperactivity disorder (ADHD), anxiety, and behavior disorders are most commonly diagnosed among adolescents age 12–17 (CDC 2021). Another analysis of Medicaid service utilization and

payments found that conduct disorder, mood disorder, ADHD, and anxiety were the most common psychiatric disorders for children and adolescents in foster care covered by Medicaid or CHIP in 2011 (Pires et al. 2018).

[15] Other studies have found that the prevalence of mental health conditions among adolescents in foster care is higher than what we observed. For example, one analysis found that nearly 57 percent of adolescents 12–17 in foster care enrolled in Medicaid had a mental health diagnosis (SAMHSA 2013). This study used Medicaid claims data to estimate the prevalence of psychiatric conditions that are commonly diagnosed among adolescents in foster care, such as attention-deficit, conduct, and disruptive behavioral disorders. In contrast, the NSDUH estimates the prevalence of MDE based on self-reported data. Estimates may also vary because the NSDUH excludes residents of institutional group quarters, such as congregate care settings, where the prevalence of psychiatric conditions is higher compared to other foster care settings (ACF 2015).

[16] Due to the limited sample size, we are unable to estimate the prevalence of mental health conditions among youth covered by Medicaid or CHIP who stayed overnight in foster care by race and ethnicity (MACPAC 2021).

[17] Due to the small sample size, we could not estimate the prevalence of suicidal thoughts and behaviors for youth with private insurance who stayed in foster care. The sample size is also too limited to report estimates for Medicaid and CHIP beneficiaries by race and ethnicity and sex (MACPAC 2021).

[18] Respondents who report illicit drug or alcohol dependence or abuse are considered to have an SUD (SAMHSA 2020a).

[19] Due to the small sample size, we are unable to estimate the prevalence of substance use among youth with private insurance who stayed in foster care. Similarly, the sample size is too limited to report estimates for Medicaid and CHIP beneficiaries by race and ethnicity and sex (MACPAC 2021).

[20] Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

[21] Due to the small sample size, we are unable to estimate access to substance use treatment for youth with private insurance who stayed in foster care. Similarly, the sample size is too limited to report estimates for Medicaid and CHIP beneficiaries by race and ethnicity and sex (MACPAC 2021).

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APPENDIX A: Mental Health Treatment by Sex

TABLE A-1. Mental Health Treatment among Non-Institutionalized Youth Age 12–17 Enrolled in Medicaid or CHIP Who Stayed Overnight in Foster Care in the Past 12 Months, by Sex, 2015–2019

Treatment characteristics	Percentage of youth age 12–17	
	Male	Female
Received non-specialty mental health services	100.0%	100.0%
Received specialty mental health services	71.3	87.6
Received specialty inpatient mental health services	52.5	58.8
Received specialty outpatient mental health services	59.5	67.4
Stayed overnight in a hospital	45.6	51.1
Stayed overnight in a residential center for emotional treatment	42.4	47.8
Spent time in a day treatment program	37.2	39.8
Received specialty treatment from a private therapist, psychologist, psychiatrist, social worker, or counselor	33.1	43.3
Received specialty treatment from an in-home therapist, counselor, or family preservation worker	37.8	23.2
Received specialty treatment from a family doctor or pediatrician	29.2	23.3

Notes: The 2019 National Survey on Drug Use and Health defined specialty mental health services as treatment or counseling for emotional or behavioral problems provided in outpatient, inpatient, or residential mental health settings. Outpatient settings include: (1) private therapists, psychologists, psychiatrists, social workers, or counselors; (2) mental health clinics or centers; (3) partial day hospitals or day treatment programs; and (4) in-home therapists, counselors, or family preservation workers. Inpatient settings include hospitals and residential treatment centers. Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

Source: MACPAC analysis of the 2015–2019 National Survey on Drug Use and Health, 2021.