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Caregiver perceived barriers to preventing unintended pregnancies and sexually transmitted infections among youth in foster care

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A B S T R A C T

Youth in foster care are at high risk of early, unintended pregnancies and sexually transmitted infections (STIs). Foster and kinship caregivers represent a potentially underutilized pregnancy and STI prevention resource. We explored foster and kinship caregivers' perspectives on barriers to communicating and monitoring foster youth around sexual health. We conducted 11 semi-structured focus groups with a diverse sample of 86 foster and kinship caregivers of adolescents in foster care. We analyzed data using Theoretical Thematic Analysis. Caregivers described institutional, relational, and individual barriers in three main thematic categories: 1) contributors to youth pregnancy and STI risk, including: pre-existing mental health and behavioral problems, pregnancy ambivalence, biological family and peer influences, and institutional barriers to reproductive healthcare access; 2) perceived barriers to communication about sex, including: discordance between caregiver and youth regarding generation, gender, or sexual orientation, youth developmental delays, caregiver lack of sexual health knowledge, and perceptions that talking about sex was against policy or put caregiver at risk of abuse allegations; and 3) perceived barriers to effective monitoring, including: lack of information about youth's prior risk behaviors or trauma, different or non-existent rules in past homes, difficulty matching strategies to the youth's developmental stage, and insufficient resources to appropriately supervise high needs youth. Foster and kinship caregivers encounter unique and complex challenges to promoting sexual health in youth in foster care. Training caregivers to tailor communication and monitoring strategies to a youth's developmental level and individual needs may be particularly helpful in helping caregivers reduce these barriers. Caregivers and youth would also likely benefit from clear messaging from child welfare agencies encouraging sexual health discussions and facilitation of access to reproductive healthcare.

1. Introduction

1.1. Youth in foster care and reproductive health risks

Although teen births are continuing to decrease in the United States (Martin, Hamilton, & Osterman, 2018), current and former youth in foster care remain at very high risk of early, unwanted pregnancies (Courtney et al., 2005; Courtney et al., 2016; Putnam-Hornstein & King, 2014). About 50% of young women in foster care report having had at least one pregnancy by age 19, and young men report higher rates of paternity as well (Courtney et al., 2005; Courtney et al., 2016). The majority of these pregnancies are unintended (Courtney et al., 2005; Courtney et al., 2016). Youth in foster care of any gender are also at 3–14 times increased risk of contracting several and sexually transmitted infections (STIs) when compared with non-foster youth peers (Ahrens et al., 2010; Shields et al., 2004; Surratt & Kurtz, 2012). Early pregnancies are associated with physical health, mental health, and economic costs across the lifespan including lower personal educational and economic attainment as well as poorer educational, behavioral, and health outcomes in offspring (Courtney et al., 2011; Department of Social and Human Services Office of Adolescent Health, 2016; Power to Decide, 2018). STIs have also been linked with significant economic costs and health risks including infertility, life-threatening infections, adverse birth outcomes, increased risk of certain types of cancers, and risk of acquiring other STIs (World Health Organization, 2016).

High rates of early, unintended pregnancies and STIs among youth in foster care are likely due to a complex interwoven set of pre-disposing factors including exposure to early adverse childhood experiences such as poverty, abuse, other forms of trauma, neglect, parental substance abuse, interpersonal violence, disrupted relationships with biological and other caregivers, and racial disparities in referral to and outcomes within the child welfare system (Courtney et al., 2005;

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E-mail addresses: katie.albertson@seattlechildrens.org (K. Albertson), julia.crouch@seattlechildrens.org (J.M. Crouch), wau2@uw.edu (W. Udell), aschimmelbristow@loyola.edu (A. Schimmel-Bristow), serranoj@ohsu.edu (J. Serrano), kym.ahrens@seattlechildrens.org (K.R. Ahrens).

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Courtney et al., 2007; Courtney et al., 2016; Maloney, Jiang, Putnam-Hornstein, Dalton, & Vaithianathan, 2017; McGuinness, Mason, Tolbert, & DeFontaine, 2002; Shaw, Putnam-Hornstein, Magruder, & Needell, 2008). As a result of these factors, foster youth have higher rates of many sexual risk and related behaviors (e.g. substance use) that predispose them to early, unintended pregnancies and STIs such as earlier sexual debut, higher numbers of lifetime, recent, and infected partners, inconsistent condom and birth control use, and higher rates of engagement in sex for drugs or money compared with peers (Ahrens et al., 2010; Alexander, 1993; Carpenter, Clyman, Davidson, & Steiner, 2001; Courtney et al., 2005; Courtney et al., 2007; Courtney et al., 2016; Crocker & Carlin, 2002; Gauthier, Stollak, Messe, & Aronoff, 1996; Hacker, Belgrave, Grisham, Abrams, & Colson, 2013; Polit, Morton, & White, 1989).

Though effective youth-focused programs have been developed to reduce sexual risk behaviors in other groups, few have been evaluated specifically in youth in foster care (Becker & Barth, 2000; Boustani, Frazier, & Lesperance, 2017; DiClemente et al., 2008; McGuinness et al., 2002; Santelli, DiClemente, Miller, & Kirby, 1999; Slonim-Nevo & Auslander, 1996). Furthermore, among those that have been studied in this or other groups exposed to maltreatment and adversity, many have demonstrated incomplete or inconsistent long-term impacts across targeted risk behaviors (Oman, Vesely, Green, Fluhr, & Williams, 2016; Rotheram-Borus et al., 2003; Slesnick & Kang, 2008; St. Lawrence, Crosby, Belcher, Yazdani, & Brasfield, 1999). Experts have advocated for tailored approaches that integrate aspects of youths' larger support networks to improve outcomes for this and other groups at high risk of unintended pregnancies and STIs (Rotheram-Borus et al., 2009b; Rotheram-Borus, Ingram, Swendeman, & Flannery, 2009a).

1.2. Evidence on parent-oriented interventions to reduce reproductive health risks

Research conducted on non-foster youth strongly indicates that brief, parent-oriented interventions that emphasize communication and monitoring skills can significantly decrease sexual risk behaviors (DiClemente et al., 2008; Kirby & Laris, 2009; Milburn et al., 2012; Prado et al., 2012; Rotheram-Borus, Ingram, et al., 2009a; Rotheram-Borus, Swendeman, et al., 2009b; Santelli, Diclemente, Miller, & Kirby, 1999; Stanton et al., 2004; Yang et al., 2006).

The limited research on this topic conducted in foster care settings also suggests that caregivers may be a promising strategy for this group (Dworsky & Dasgupta, 2014; Kerr, Leve, & Chamberlain, 2009; Love, McIntosh, Rosst, & Tertzakian, 2005). Non-intervention research that has focused on understanding risk and protective factors for early pregnancies and STIs among youth in foster care similarly highlights the importance of caregivers. For example, in a longitudinal study evaluating youth in foster care as they aged out of care, having a close relationship with a foster or kinship caregiver and remaining in care longer were associated with significantly decreased sexual risk behaviors (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013). Similarly, in a qualitative study youth participants described caregiver factors they felt were protective against unintended pregnancies and STIs, including frank discussions about condom/contraceptive use, enforcement of rules in a consistent yet respectful manner, and positive coaching regarding communication and other skills (Ahrens, Spencer, Bonnar, Coatney, & Hall, 2016).

Given that caregivers frequently care for multiple youth over time, well-trained caregivers have the potential to influence many youth over the course of their experiences as caregivers. However, foster and kinship caregivers are likely to face many barriers to preventing pregnancy and STI among the youth they serve. A lack of long-term experience with foster youth in their care, child welfare institutional factors, and pre-existing behavioral, mental health, and trauma-related issues among youth in foster care may interfere with caregivers' abilities to engage these youth in conversations around sex and effectively monitor and enforce rules (Anda et al., 2006). As of yet, no studies have specifically focused on understanding the needs of foster and kinship caregivers to help them more effectively communicate and monitor youth around sexual health (Love et al., 2005).

1.3. Study objectives

In this study, we sought to explore barriers to pregnancy and STI prevention in youth in foster care from the perspectives of foster and kinship caregivers. Our goal was to use data to inform the development of a tailored training for caregivers.

2. Methods

2.1. Recruitment

We partnered with the Washington State Department of Social and Health Services, the Los Angeles County Department of Children and Family Services, and two private foster care agencies in New York State to employ a maximum variation purposive sampling technique and recruit a diverse sample of 86 foster and kinship caregivers who had provided care to a foster youth aged 11–18 for at least 3 months in the past year. Participating agencies were given scripts to contact caregivers via email, letter, and/or telephone (based on agency preference regarding which would work best for their caregivers) to provide information on the study. We deliberately included participants from three different child welfare jurisdictions to get variation in terms of caregiver race/ethnicity, geographical location, and characteristics of the youth they serve. We also sought diversity in age and caregiving experience and asked agencies to recruit caregivers of various ages and levels of experience, but did not employ specific techniques to ensure variations on these characteristics.

2.2. Focus groups

Eleven focus groups were conducted by eight racially and ethnically diverse female leaders (2 African American women, 2 white women, and 3 Latina women), all but two of whom were highly experienced in conducting focus groups. Three of the leaders were members of the research team, the other five were part of a community-based child welfare agency in New York (2 leaders) or a non-profit with significant experience working with foster youth and caregivers in Los Angeles (3 leaders). Focus groups contained 5–10 participants and lasted approximately 1.5–2 h. Eight focus groups were conducted in English (4 in Los Angeles, 1 in Seattle, and 3 in New York) and 3 were conducted in Spanish (2 in Los Angeles and 1 in New York). Prior to each focus group, we obtained written consent and asked participants to complete a brief survey on demographics and caregiving experiences. Leaders used open-ended, semi-structured scripts focused on understanding barriers to communication and monitoring of foster youth related to sexual health (Table 1). Caregivers received $60 for participating, as well as reimbursement for childcare and transportation. Focus groups were audio recorded, transcribed, translated (if applicable), and reviewed for accuracy. The Washington State Institutional Review Board approved all materials and procedures.

2.3. Analysis

We used Theoretical Thematic Analysis (Braun & Clarke, 2006), a six phase coding process that includes: 1) familiarizing oneself with data, 2) generating initial codes, 3) searching for themes among codes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the final report. During Phase One, we conducted a close reading of transcripts to establish familiarity with the data and made note of emerging themes. During Phase Two, we generated a list of recurring themes or “codes.” In Phase Three, we employed an inductive approach