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# Sexual and reproductive health policies for foster youth in California: A qualitative study of child welfare professionals' experiences and perceptions of policies

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ABSTRACT

Child welfare professionals and foster parents increasingly suggest the importance of establishing clear and consistent policies and procedures to address the sexual and reproductive health of youth in foster care. The present study examines the content and context of such policies across 18 California counties through a search of publically available county policy documents, and surveys and expert interviews with child welfare professionals (N = 22). A policy framework for agenda setting and policymaking was used to guide the data collection and analysis process. Child welfare professionals were aware of multiple sources of information, support and services for foster youths' sexual and reproductive health, though few practiced in counties with formal policies that outline the resources and support that youth should receive. Participants demonstrated widespread recognition that issues of youth sexual and reproductive health were significant; posing challenges to youth, foster parents and child welfare staff. Identified policy solutions included: 1) training for social workers and foster parents; 2) collaborative partnerships with public health nurses and community providers; 3) data tracking and monitoring of outcomes to assess youth needs and evaluate the impact of programs and policies; and 4) involvement by advocacy organizations in defining problems and advocating for improved services and support for youth in care. Social workers largely perceived that support from child welfare administrators and policy leaders is necessary to prioritize this issue and initiate policy formation. Additional research is needed to further examine the impact of policy mandates on social workers, foster parents and youth in foster care.



## 1. Introduction

Children and youth in foster care are among the most vulnerable populations in the U.S. In 2010 the Adoption and Foster Care Analysis Reporting System (AFCARS) reported that nearly 400,000 children were living in out-of-home placements (U.S. Department of Health and Human Services, 2013). As a result of the trauma, abuse and neglect that children in foster care encounter prior to entering care and as a consequence of their experiences in the child welfare system (e.g. frequent placement changes, duration in the foster care system), they are at increased risk for a host of physical health problems (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Jee & Simms, 2006; Kools & Kennedy, 2003). It has been estimated that one in two children in foster care has a chronic medical condition unrelated to behavioral issues (Diaz et al., 2004). Many children enter care with a history of poor health care utilization, often arriving into care with multiple unmet health care needs (Risley-Curtiss, Combs-Orme, Chernoff, & Heisler, 1996). Children and youth who have been exposed to abuse and neglect additionally experience increased behavioral and mental health issues including emotional dysregulation, insecure attachment behaviors, anxiety, post-traumatic stress disorder, and depression (Jee, Tonniges, & Szilagyi, 2008; Leslie et al., 2005; Massinga & Pecora, 2004; Pilowsky, 1995; Sawyer, Carbone, Searle, & Robinson, 2007; Stirling & Amaya-Jackson, 2008).

Approximately one third of the children in foster care are adolescents of reproductive age (14–20 years) (Svoboda, Shaw, Barth, & Bright, 2012). These youth are distinct from the general U.S. adolescent population in terms of sexual risk behaviors. Foster care is associated with younger age at first intercourse, greater number of sexual partners, and low contraceptive use (Carpenter, Clyman, Davidson, & Steiner, 2001; Polit, Morton, & White, 1989). Some documented risk factors associated with sexual risk behaviors include delinquency, relationships with deviant peers (James, Montgomery, Leslie, & Zhang, 2009), drug use, serious mental health and behavioral problems, and history of sexual abuse (Polit et al., 1989; Risley-Curtiss et al., 1996).

As a result of risk-taking behaviors, youth in foster care are at increased risk for sexual transmitted infections (STIs), adolescent pregnancy and early childbearing (Carpenter et al., 2001; Dworsky & Courtney, 2010; James et al., 2009; Leslie et al., 2010; Polit et al., 1989; Risley-Curtiss, 1997; Svoboda et al., 2012). Studies demonstrate that youth in care are more likely to be exposed to and acquire STIs and

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HIV than their adolescent counterparts not in care (Ahrens et al., 2010; Robertson, 2013). A longitudinal study of foster youth (Midwest Study) finds that 33% of young women in foster care had ever been pregnant by age 17 or 18, compared to only 14% of their adolescent counterparts not in care (National Longitudinal Study of Adolescent Health). By age 19, the gap widens with over half of the youth in foster care having ever been pregnant verses 20% among adolescents not in care (Courtney & Dworsky, 2006; Dworsky & DeCoursey, 2009). A study of cumulative teen birth rates in California finds that 28% of girls in foster care had a first birth by age 20. The study demonstrates that higher birth rates are associated with black and Latina race/ethnicity, >4 placements, shorter lengths of time in care, and runaway status at the time of final exit from care (Putnam-Hornstein & King, 2014). Studies also show that youth in foster care, particularly those with a history of childhood sexual abuse, are at increased risk for sexual exploitation and transactional sex (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Wilson & Widom, 2008).

The consequences of early pregnancy and childbearing for youth in foster care differ from their adolescent counterparts not in care. Young parents in foster care are extremely vulnerable, as they may not have the physical and emotional support, and safety net systems to effectively cope with a teen birth (Chase, Maxwell, Knight, & Aggleton, 2006; Svoboda et al., 2012). In a study of foster youth in New York City by Gotbaum, Sheppard, and Woltman (2005), pregnant and parenting youth note facing multiple hardships due to lacking and insufficient services and resources for pregnant or parenting youth. The children born to youth in care are also at increased risk for abuse, neglect, and placement in foster care (Bilchik & Wilson-Simmons, 2010; Gotbaum et al., 2005).

Qualitative studies with foster youth reveal that some youth perceive benefits associated with early childbearing, such as the desire to have someone to love and be loved by, and to have a family of their own who can help fulfill their emotional needs (Barn & Mantovani, 2007; Knight, Chase, & Aggleton, 2006; Love, McIntosh, Rosst, & Terzakian, 2005). Becoming pregnant and having a child is viewed as a way to hold on to a partner (Constantine, Jerman, & Constantine, 2009), bring greater purpose to succeed in life, or provide a way out of a harmful lifestyle (Chase et al., 2006; Haight, Finet, Bamba, & Helton, 2009; Pryce & Samuels, 2010). Youth in foster care experience strong pressure from their peers to have sex, as adolescent pregnancy is often accepted by youths' peers and also by one's family of origin. According to Constantine et al. (2009) these findings demonstrate attitudinal motivations in favor of early childbearing. The authors note that even if youth have access to contraceptives and family planning information, motivations for pregnancy might outweigh pregnancy prevention efforts. While it is impossible to discount the potential for positive outcomes associated with early childbearing identified by Love et al. (2005) and Pryce and Samuels (2010), foster youth are a unique and vulnerable population that deserves special consideration with respect to the promotion of healthy sexual and reproductive health (James et al., 2009; Leslie et al., 2010).

The World Health Organizations (WHO) defines sexual health as a "state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence." (World Health Organization, 2006, p. 5). This affirmative definition of sexual health extends beyond traditional messages centered on avoiding STIs and unwanted pregnancies and serves as a basis for examining the sexual and reproductive health of all adolescents, including those in foster care (Aggleton & Campbell, 2000).

Marginalized groups of adolescents are often denied access to information and services which hampers their ability to make informed decisions and achieve positive sexual and reproductive health (Aggleton & Campbell, 2000). An empirical review of the literature by Robertson (2013) found that youth in foster care face multiple barriers to accessing sexual and reproductive health services. Barriers include financial difficulties, service delivery issues, lack of accurate and timely sexual health information, concerns regarding privacy and confidentiality, and insufficient of policies (Robertson, 2013). Compared to their peers not in care, children and youth in foster care are less informed about contraceptive options and sexuality, and less likely to obtain needed family planning resources and sexual health information (Polit et al., 1989). Furthermore, some youth distrust the effectiveness of contraceptives or doubt that a pregnancy will happen to them; perceptions that might stem from misunderstandings of how contraceptives work (Chase et al., 2006; Love et al., 2005).

Youth in foster care express a desire for consistent and enduring relationships with caring adults with whom they can discuss love, sex, and relationships (Constantine et al., 2009; James et al., 2009). While strong relationships between adolescents and their parents have been found to be critical in the prevention of teenage pregnancy and other risky behaviors (Blum & Rinehard, 1998), youth in foster care often lack connections to trusted and knowledgeable adults with whom they can discuss sexual health issues; resulting in non-existent or ineffective conversations (Bilchik & Wilson-Simmons, 2010; Knight et al., 2006). Inconsistent relationships with trusted adults, frequent placement changes, and ongoing developmental needs are barriers to youth having conversations about making healthy sexual health decisions, and preventing STIs and unplanned pregnancies (Haight et al., 2009; Max & Paluzzi, 2005). Personal relationships are particularly important for these youth, as placement in foster care puts them at increased risk for interpersonal disconnection and leaves them without the social networks they need to support healthy sexual and reproductive health (Love et al., 2005).

As a result of multiple placement changes and disruptions in education, many youth in foster care often experience incomplete and haphazard sources of sexual and reproductive health information through county-based independent living programs (ILP), school-based sexuality education classes, interactions with medical providers, community resources, and unstructured discussions with social workers and foster parents (Constantine et al., 2009; Hudson, 2012). A study by Hudson (2012) found that among foster youth 18–24 years old in California, many participants only received the message of abstinence in school-based sex education programs. Half of the males in this study also noted that they had not received pregnancy prevention information during visits with primary care providers (Hudson, 2012). For many youth in foster care, the quality and content of the information that they receive regarding their sexual and reproductive health may be too little and/or too late to have an appreciable impact. (Love et al., 2005).

Child welfare professionals and foster parents are potential sources of sexual health information and support for youth, yet many of these individuals are unsure who is responsible for having conversations with youth (Constantine et al., 2009; James et al., 2009). Studies by Constantine et al. (2009) and Love et al. (2005) found that social workers and foster parents believe that they are unprepared to talk to youth about these issues, citing lack of training, conflicting values and discomfort with the topics as major barriers. A similar study of foster parents and youth in the United Kingdom found that the strong personal views among some foster parents prevented them from providing information and support to youth in their care (Knight et al., 2006). In spite of these barriers, studies with social workers and foster parents also find that many desire training to help them talk to youth in foster care, and to help facilitate communication around this sensitive issue (Dworsky & Dasgupta, 2014; Risley-Curtiss, 1997).

Studies with child welfare staff, foster parents, and youth in foster care increasingly suggest the importance of establishing clear and consistent policies and procedures to outline the role and responsibilities of social workers and foster parents with respect to youth sexual and reproductive health needs (Constantine et al., 2009; Love et al.,