

# 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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## ARTICLE INFO

### Article history:

Received 10 June 2015

Received in revised form 15 December 2015

Accepted 15 December 2015

Available online 19 December 2015

### Keywords:

Foster care  
Sexual health  
Social workers  
Policies

## 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 publicly 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.

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## 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 versus 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 Organization (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.,

2005; Max & Paluzzi, 2005). It is believed that written policies and procedures will further define roles and responsibilities, stipulate needed training for providers, and clarify issues of liability, parental rights, and youth rights to privacy and confidentiality (Boonstra, 2011; Collins, Clay, & Ward, 2007; Haight et al., 2009). Constantine et al. (2009) and Love et al. (2005) further note that policies are necessary to ensure that pregnant and parenting foster youth receive information and counseling regarding their pregnancy options, opportunities to prevent subsequent pregnancies, and parenting resources. Clear written policies can explicitly stipulate that youth receive accurate and timely information regarding their sexual and reproductive health, and access to community resources and services including “non-biased and non-judgmental information” (Constantine et al., 2009; Haight et al., 2009; Knight et al., 2006, p. 67).

Most states have written policies in place that outline the health care for children in foster care (Risley-Curtiss & Kronenfeld, 2001). To date only two studies have explicitly examined statewide policies related to foster youth sexual and reproductive health. An early survey of child welfare professionals by Polit, White, and Morton (1987) found that across 48 U.S. state agencies only nine states had written policies detailing the provision of family planning services. These policies mostly included brief statements regarding allowable social worker roles and responsibilities. The authors further discovered that only two states had comprehensive policies that addressed the sexual development of foster youth. Identified barriers to policy development included political opposition to addressing issues of family planning, legal constraints (i.e. parental rights, parental consent), and administrative barriers (i.e. high caseloads, lack of funding) (Polit et al., 1987). In 1996, Mayden (1996) conducted a survey of all 50 U.S. states and the District of Columbia and found that only 10 states had written policies that addressed sexuality education and/or family planning services for youth in foster care. Seventeen states provided training for social workers, and only 11 states offered training for foster parents. The study suggested that policy shortcomings contributed not only to the overall confusion with respect to reproductive health policies for foster children and youth, but also to the inadequate response by child welfare agencies to address the need for pregnancy prevention (Mayden, 1996). Despite the nearly 10-year gap, these studies demonstrate minimal progress toward advancing statewide policies addressing the sexual and reproductive health of youth in foster care.

Given the heightened sexual risk behaviors and the prevailing rates of teen pregnancy and childbearing among youth in foster care, there is a continued need to better understand the role that policies play in supporting healthy sexual and reproductive health for youth in care (Constantine et al., 2009; Love et al., 2005; Svoboda et al., 2012). The present study aims to examine the content and context of sexual and reproductive health needs, challenges and policies for youth in foster care across counties in California. This study specifically explores the following issues from the perspectives of child welfare professionals: (1) youth needs and challenges; (2) barriers to addressing youth needs, (3) existing policy guidelines and procedures related to addressing youth needs; and (4) key issues relevant to county-level policy formation. Policy theories for agenda setting and policy formation are used to guide the study conceptualization, design and analysis.

## 2. Policy theory

Kingdon's (1984) model of agenda setting and policymaking denotes a policy process that is unpredictable and dynamic, with elements of both order and disorder. Agenda setting within the policymaking process is a complex and unpredictable process of defining problems and identifying policy solutions within a highly political policy environment. Within this policy context, if a problem is sufficiently recognized, a policy solution is deemed available, and the political climate is right, the convergence of policy elements will allow

for an issue to move from discourse to a public agenda for policymaking (Kingdon, 1984; Weissert & Weissert, 2006).

Stone (2002) expands upon Kingdon's model by describing the role of causal stories in defining problems for public discourse. Stone describes a process of “active manipulation of images of conditions by competing political actors” to set the parameters necessary to discuss and bring legitimacy to an issue (Stone, 1989, p. 299). Stone explains the role of political actors in creating causal stories that articulate the harms and difficulties associated with a particular issue. They attribute causes to the actions of individuals and/or organizations in an effort to invoke the need for governments to address the problem and use their “power to stop the harm” (Stone, 1989, p. 289). Causal stories have multiple uses in the political sphere that include: 1) challenging or protecting existing rules, institutions and interests; 2) assigning responsibility for fixing a problem to particular policy actors; 3) legitimizing and empowering actors in their role as “fixers” of the identified problem; and 4) creating new political alliances among individuals perceived to be similarly harmed by the problem (Stone, 2002).

Policy theorists emphasize the significant role of policy entrepreneurs in developing and articulating problems and policy solutions that are deemed plausible and compelling given current political conditions (Mucciaroni, 1992). Successful policy entrepreneurs use their skills and persistence to formulate linkages and negotiate with stakeholders to seize opportunities for agenda setting (Baumgartner & Jones, 1991, 2009; Kingdon, 1984). Policy entrepreneurs include but are not limited to: appointed legislative staff, lobbyists, academics, lawyers, journalists, and bureaucrats (Weissert & Weissert, 2006).

The aforementioned policy theories provide a broad framework for examining the complex and unpredictable policy formation process. Issues of problem definition, policy solutions, role of policy entrepreneurs, and agenda setting were examined with respect to the sexual and reproductive health of foster youth in California.

## 3. Methods

An examination of the content and context of sexual and reproductive health needs, challenges and policies for youth in foster care in California was conducted through 1) a document review of publically available county policy documents, 2) a county-level survey of existing policy and procedural information, and 3) expert interviews with county individuals knowledgeable in the area of sexual and reproductive health for youth in foster care. Data were collected from May through August of 2012. The Institutional Review Board of the University of California Berkeley approved the study protocol and recruitment methods.

### 3.1. County sampling criteria

To identify a sub-sample of California counties to participate in the study, purposeful sampling (Patton, 2002) was used to identify counties with a sufficiently large total foster care population to adequately reflect on the sexual and reproductive health issues of youth in foster care. The sampled counties included those with a total foster care population (2010) greater than 240 children and youth as well as county-level teen birth rates greater than 18 births (per 1000). It should be noted that the teen birth rates were for all county teens (15 to 19 years), and did not represent data for youth in foster care only. The purpose of selecting a sub-sample of counties with higher total foster care populations and countywide teen birth rates stemmed from preliminary conversations with child welfare professionals from counties with smaller total foster care populations who indicated that they did not oversee enough youth in foster care to think about such issues; nor did they believe that they had substantial experience supporting pregnant or parenting teens. Based on these preliminary findings the inclusion criteria were designed to identify counties that would be able to

sufficiently reflect on the sexual and reproductive health of youth in foster care. Twenty-six counties were targeted for participation (Fig. 1).

3.2. Participant sampling and recruitment

Purposeful sampling was used to identify one to two child welfare representatives from each county who were knowledgeable about the sexual and reproductive health of youth in foster care (Barbour, 2001; Patton, 2002). A web-based search of county Social Services Agency websites was conducted to obtain publically available contact information for child welfare administrators (i.e. Directors, Associate Directors, Division Managers), program managers and social work supervisors. These individuals were contacted via telephone and email. Potential participants were provided with a description of the study and asked to participate in the web-based survey and expert interviews. In cases where the primary contact did not believe that he/she was the most knowledgeable in this area, they were asked to identify another county representative with relevant insight and knowledge about the sexual and reproductive health of youth in foster care in their respective county.

3.3. Policy document review protocol

A document review of policy documents available online through county departments of social services was conducted to examine any existing policy statements or documents outlining existing services, resources and support for the sexual and reproductive health of youth in foster care. The online search was performed prior to conducting the county surveys and expert interviews. Search terms included the individual county name along with “policy,” “practices,” “administrative guides,” “sexual health,” or “reproductive health.” The primary websites examined included county departments of family and children’s services, social services, and health and human services.

3.4. Web-based survey and expert interview protocol

Upon consent to participate, all county representatives received a link to a confidential online survey administered through Survey Monkey®. The survey included three demographic and nine content questions. The content questions examined current sexual and reproductive health services for foster youth, child welfare staff roles and responsibilities, awareness of resources, training practices, data monitoring, and county policies and procedures. Participants were asked to complete the online survey prior to the interview to allow

the study author to review the findings prior to the interview and tailor the discussion based on current practices and policies.

The expert interviews included open-ended questions and prompts that were used to increase the breadth and depth of responses, and to allow participants the opportunity to express relevant experiences and insights in an unrestricted manner (Miles, Huberman, & Saldaña, 2013). The interview guide was developed using applicable policy theories regarding agenda setting and policy formation, including issues of problem definition, issue prioritization, policy solutions, role of policy entrepreneurs, political environment, and current or past policy formation experiences (Baumgartner & Jones, 1991, 2009; Kingdon, 1984; Stone, 2002). The questions were piloted and revised following an interview with a child welfare worker who was instrumental in developing a countywide sexual and reproductive health policy for youth in foster care. The interviews were conducted via telephone by the study author and designed to last approximately 30–40 min. In cases where there were multiple study participants for one county, joint interviews were conducted and survey responses were reviewed to ensure consensus. All interviews were digitally recorded, transcribed verbatim and reviewed for accuracy by the study author and a research assistant.

3.5. Qualitative theme analysis of expert interviews

Verbatim interview transcripts were coded using the theories of agenda setting and policy formation as an a priori framework to guide coding and analysis. In cases where the theoretical framework was insufficient, new codes were generated inductively through a data driven approach (Fereday & Muir-Cochrane, 2006). Subsequent reviews of the coded excerpts by domain and broad topic area resulted in approximately three revisions of the codebook until the final codebook adequately reflected the coded data. The coded excerpts were iteratively sorted, organized and refined during the process of identifying emergent concepts, patterns and preliminary themes (Miles et al., 2013; Saldana, 2009).

Manual transcript-based theme analysis was subsequently conducted using an iterative process of reviewing and highlighting coded excerpts to identify relevant themes for each broad topic area (Bertrand, Brown, & Ward, 1992; Krueger, 1994; Ryan & Bernard, 2003). Themes were assigned succinct phrases that appropriately described each predominate theme, and exemplary quotes were identified (Fereday & Muir-Cochrane, 2006). Approximately eight rounds of re-organization and compression of themes took place until themes were finalized. QSR International’s NVivo 10© software was used to facilitate the analysis process. The software was used to input, organize, memo, and code data from the expert interviews (Fonteyn, Vettese, Lancaster, & Bauer-Wu, 2008).

The study author was solely responsible for conducting the analysis process. Prior to conducting this study, the author had over 10 years experience in the public health field leading and evaluating community programs, and conducting qualitative research. Given that the study author does not have professional experience in the field of social welfare, multiple steps were taken to strengthen the credibility of the study findings. First, the author employed an internal audit trail that included written field notes to detail and describe each interview, interviews that were audiorecorded and transcribed verbatim, and memos used to document the coding and analysis process (O’Brien, Harris, Beckman, Reed, & Cook, 2014). Second, two public health faculty not associated with the study provided extensive feedback on the sorting and refinement of themes. Finally, three dissertation advisors with expertise in health policy, public health and social welfare comprehensively reviewed the findings. The incorporation of multiple perspectives throughout the critical review process was designed to assess and check the potential influence and biases of the study author, and to strengthen the interpretation and credibility of the data (Malterud, 2001). The

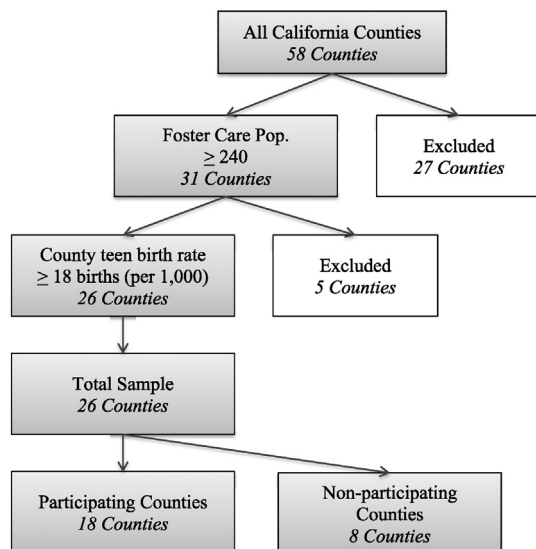


Fig. 1. County sampling.

present study was conducted as part of a doctoral dissertation in public health.

## 4. Results

### 4.1. County characteristics

Of California's 58 counties, 26 met the sampling criteria and representatives from 18 counties agreed to participate (69% response rate) in both the online survey and the expert interview. Among the eight non-participating counties: six attempted to identify a suitable representative but ultimately did not participate; one declined to participate, and one did not respond to requests (Fig. 1). Participating counties had populations that ranged from 244 (Imperial) to 18,883 (Los Angeles) total children and youth in foster care. These counties reflected the inclusion of counties with sufficiently large populations of youth in foster care to reflect on issues of sexual and reproductive health. County teen birth rates for participating counties ranged from 19.3 (San Luis Obispo) to 59.3 (Tulare) births (per 1000). Participating counties had a median teen birth rate of 35.5 births (per 1000), which was higher than the median of 25.9 births (per 1000) across all California counties. The participating counties represented seven of the 11 voting regions in California as defined by the California Voter Foundation (2012); missing counties that represented the North Coast, Wine Country, Gold Country and Eastern Sierra. The racial and ethnic composition of participating counties varied, with 13 of the 18 counties having a Hispanic/Latino foster care population  $\geq$  50% (Table 1).

### 4.2. Participant characteristics

Fourteen counties identified one designated representative participate in the survey and the interview, and four counties had two individuals jointly participate for a total of 22 participants across 18 counties. Of the study participants nearly all were female ( $N = 21$ ), with the majority having worked six or more years in child welfare. The positions and titles of study participants included directors, social work supervisors, program managers, public health nurses, and Independent Living Program (ILP) coordinators. Directors, supervisors

and managers were more likely to report being responsible for overseeing particular department programs or initiatives. Three participants indicated that their role was specifically related to policy oversight, including issues of policy development, management, and implementation. Two Deputy/Assistant Directors of Social Services participated, along with two public health nurses who provided insights regarding their collaborations with their respective child welfare departments (Table 2).

### 4.3. Sources of information, services and support youth in foster care and child welfare professionals

Survey findings revealed that participating child welfare professionals cited multiple sources of sexual and reproductive health information, services and support for youth in foster care. These sources included: schools, medical providers, county public health nurses, ILP programs, community-based agencies, foster parents, birth parents, and peers. Participants cited counseling and discussions with social workers (94%), ILP workshops (94%), referrals to community-based resources (94%), and visits with public health nurses (72%) as sources of information and support provided through their respective county agencies (Table 3).

Participants from 11 out of 18 counties (61%) identified social workers as primarily responsible for discussing issues of sexual and reproductive health with youth, followed by the ILP program (28%). Only four participants (22%) reported that child welfare staff were "completely aware" of the content and sources of sexual and reproductive health information and services available to youth in foster care in their county. The vast majority (78%) of child welfare staff appeared to be only "partially aware" of the available information and services. Finally, few counties offered trainings for social workers (39%), foster parents (17%) and foster youth (39%) (Table 3).

### 4.4. Policy documents and practices

A document review of policy documents available online through county departments of social services websites was conducted for each of the sampled counties. The review revealed that only two counties (Los Angeles and Santa Clara) had publically accessible

**Table 1**  
County characteristics.

	County	State region <sup>a</sup>	2010 foster care population <sup>b</sup>	2010 teen births <sup>c</sup>	2010 teen birth rate (per 1000) <sup>c</sup>	2010 race/ethnicity of children in foster care (% Hispanic/Latino, % Black, % White) <sup>d</sup>
	California		57,651	43,127	31.5	47%:25%:25%
1	Los Angeles	Southland	18,883	11,677	31.7	54%, 33%, 11%
2	Riverside	Inland Empire	3957	2918	32.0	53%, 16%, 29%
3	San Bernardino	Inland Empire	3535	3476	39.8	48%, 23%, 27%
4	Sacramento	Sacramento Valley	3274	1594	31.1	23%, 40%, 31%
5	Fresno	San Joaquin Valley	2348	2023	51.3	60%, 15%, 19%
6	Kern	San Joaquin Valley	2030	2010	58.1	50%, 13%, 36%
7	Alameda	Bay Area	1805	1059	21.7	19%, 60%, 17%
8	Santa Clara	Bay Area	1146	1176	21.2	63%, 13%, 18%
9	Tulare	San Joaquin Valley	803	1122	59.3	66%, 4%, 28%
10	Merced	San Joaquin Valley	703	509	43.2	57%, 12%, 25%
11	Ventura	Southland	622	932	29.9	60%, 5%, 33%
12	Santa Barbara	Central Coast	552	638	33.9	70%, 5%, 24%
13	Shasta	Northern Mountains	534	196	32.9	18%, 4%, 70%
14	Sonoma	Wine Country	503	355	22.0	32%, 7%, 54%
15	San Luis Obispo	Central Coast	321	198	19.3	31%, 5%, 62%
16	Monterey	Central Coast	287	775	49.1	72%, 9%, 18%
17	Kings	San Joaquin Valley	267	298	55.3	53%, 19%, 26%
18	Imperial	Inland Empire	244	417	56.7	84%, 4%, 8%

<sup>a</sup> The California Voter Foundation (2012). "Regional Map." California Map Series. Retrieved Aug. 1, 2012; Available from <http://www.calvoter.org/voter/maps/index.html>.

<sup>b</sup> Center for Social Services Research (2012). "Point-In-Time counts of children in foster care." Child Welfare Dynamic Report System. Retrieved July 1, 2012; Available from [http://cssr.berkeley.edu/ucb\\_childwelfare/PlacementGrids.aspx](http://cssr.berkeley.edu/ucb_childwelfare/PlacementGrids.aspx).

<sup>c</sup> Constantine, N. A., P. Jerman, et al. (2012). Teen Births in California: Spring update (County Table, 2010 state and county corrected data). No Time for Complacency. Oakland, CA, Center for Research on Adolescent Health and Development. Retrieved Nov. 2, 2015; Available from <http://teenbirths.phi.org>

<sup>d</sup> Child Welfare Information Gateway (2012). Foster care statistics 2010. Washington, DC, U.S. Department of Health and Human Services, Children's Bureau.

**Table 2**  
Participant characteristics.

Characteristic	N
Gender (N = 22)	
Female	21
Male	1
Number of years working in child welfare (N = 18) <sup>a</sup>	
0–5 years	3
≥ 6 years	15
Position/title (N = 22)	
Independent Living Program coordinator	1
Foster care social worker	3
Foster care manager/supervisor	4
Program managers/supervisor/director	7
Policy related positions: (i.e. Assist. Regional Mgr. Court & Policy; Mgr. Policy and Implementation; Oversight of Policy)	3
Deputy/Assist. Director, Social Services	2
Public health nurse	2

<sup>a</sup> Missing data for four participants.

stand-alone policies that explicitly detailed departmental guidelines and procedures for supporting youths' sexual and reproductive health needs. The two policies varied in content, but one or both outlined the following: department policy procedures, stakeholder responsibilities (i.e. social workers, foster parents, public health nurses, and foster youth), references for pertinent legal statutes, and discussion guidelines detailing allowable conversations regarding youth rights, sexuality, reproductive health, pregnancy, and teen parenting. Santa Clara County's policy also included two judicial standing orders pertaining to the reproductive and ordinary health of youth in foster care (Table 4).

Findings from the examination of publically available policy documents for Los Angeles and Santa Clara counties were confirmed by the pre-interview survey results where participants from these counties indicated the presence of a formal policy. In the survey, two additional counties indicated that they had sexual and reproductive health policies for youth in foster care. However, upon further examination and discussion with interview participants it was determined that these two counties did not have formal stand-alone policies, but rather provisions regarding youth sexual and reproductive health embedded in other policy documents. Additionally, only two counties were routinely asked to provide sexual and reproductive health information in court reports. Less than half of the participants (N = 7) believed

**Table 3**  
Sources of sexual and reproductive health information, services and support.

	Number of counties providing services (N = 18)
<i>Resources provided by child welfare agencies</i>	
Counseling and discussions with social workers	18 (94%)
ILP resources	17 (94%)
Referrals to community-based resources	17 (94%)
Visits with public health nurses	13 (72%)
<i>Provider primarily responsible for discussing issues of sexual and reproductive health with youth</i>	
Social workers	11 (61%)
Independent living programs	5 (28%)
Foster parents	1 (6%)
Community-based organizations	1 (6%)
Public school system	0 (0%)
<i>Perceived social worker awareness of the content and sources of information, services and support for youth in foster care</i>	
Completely aware	4 (22%)
Partially aware	14 (78%)
Completely unaware	0 (0%)
<i>Trainings provided by child welfare agencies</i>	
Trainings for child welfare professionals	7 (39%)
Trainings for foster parents	3 (17%)
Trainings for youth in foster care	7 (39%)

that their county collected sexual and reproductive health outcome data for youth in foster care (Table 5).

#### 4.5. Youth needs and challenges

##### 4.5.1. Sexual and reproductive health issues are significant and challenging for youth and child welfare staff

The study participants overwhelmingly identified sexual and reproductive health as a relevant issue for foster youth both while in care and following emancipation. Many participants perceived this issue to be a “huge” or “big” problem for youth. Issues that were particularly challenging included: multiple sexual partners, STIs, pregnancy, early childbearing, sexual exploitation, and trafficking of young girls for sex related activities. Some participants identified these topics as extremely difficult for youth and social workers given the complexity of these issues, the extreme vulnerability of youth, and the lack of appropriate support services and resources readily available.

*The issue is huge and we have a lot of teen pregnancies, we have a lot of STD issues. We often have to take our children in for treatment of gonorrhea, herpes, AIDS...we've had children with AIDS. We also have had a few human trafficking cases, prostitution...We've had children exploited prostituted out by their parents, so they continue to have these behaviors even in foster care. —Deputy Director*

Child welfare staff noted that many sexual and reproductive health behaviors and outcomes are linked to risk behaviors such as substance abuse. A few participants mentioned that drug use was a significant concern impacting youth in their county. Factors associated with youth placement in foster care (i.e. trauma, neglect, sexual abuse) and experiences while in care (i.e. lack of stability, running away) were also perceived linked to youth sexual and reproductive health.

*Neglect, abandonment, grief, and loss...a lot of the times the emotional issues supersede practicing safe sex and using effective methods of birth control, especially when they feel that emotional want is being met by a boyfriend, a guy; it [birth control] just goes out the window. —Social worker*

##### 4.5.2. Strong desire among youth to find love through early childbearing despite challenges

Several county representatives underscored the influence of youths' desires to be loved and to have a child. From the participants' perspectives, youth hope that by building their own families they can make up for their own challenging family lives and upbringing. Often the hope of creating a consistent and loving family predisposes youth to engage in unhealthy sexual relationships that result in an unplanned pregnancy, teen birth, and/or domestic violence. Support and guidance around these issues is challenging for youth who lack placement stability and connections with families and individuals who are invested in their lives and success.

*In our population you're dealing with emotional and family dynamics that are greater than any prevention methods that the community has to offer [and] can handle. Because you have young girls who have been neglected, abused and traumatized, and they want to be loved. So when they find that guy who they think loves them, or is giving them the fantasy of love, then everything goes to the wayside because they are so vulnerable...it supersedes any of the education, planned parenting, anything that we as case workers try to address on a monthly basis when we meet with these kids. —Social worker*

Despite the youths' often glorification of teen childbearing, child welfare staff regularly saw the realities and long term implications for parenting youth. Many vocalized their concern for pregnant and parenting youth already dealing with existing hardships and challenges

**Table 4**  
County policy documents.

County	Title	Date	Description
Los Angeles County	Procedural Guide 0600–507.10 “Youth Development: Reproductive Health”	Effective date 12/21/11	Included in Los Angeles County's online Department of Children and Family Services Policy resources. The procedural guide was part of the Child Welfare Services Handbook, under the Health Care section 0600–000. Supplemental resources included: <ul style="list-style-type: none"> <li>• Reproductive health and parenting resources for teens</li> <li>• Guide for pregnant and parenting teens</li> <li>• Child care and development resources for parenting teens</li> <li>• Community family counseling programs</li> </ul>
Santa Clara County	Procedural Guide 15.3 “Reproductive Health”	Last Updated 1/20/11	Included in Santa Clara County's online Department of Family and Children's Services Policies & Procedures. Guide 15.3 was found in online Handbook 15: Health Care. Supplemental resources included: <ul style="list-style-type: none"> <li>• Title X – Public Health Services Act</li> <li>• California minor consent laws</li> </ul>
Santa Clara County	Standing Court Order on Reproductive Health	Filed 12/15/10	Court legal document outlining the reproductive health information, services, and resources that all court involved youth should receive. Includes legal basis for providing these services.
Santa Clara County	Standing Court Order on Ordinary Health	Filed 7/11/12	Court legal document outlining the ordinary medical, mental health, and dental treatment for juvenile justice and dependent children and youth in temporary and out-of-home placement.

associated with being placed in care. They recognized that for teen parents' issues of housing, education, employment, and finances would now be “that much harder”. Parenting youth are forced to deal with issues of childcare, and the emotional and psychological stress of being young parents with few resources and support systems.

*The fact that it [teen childbearing] leads to them living in a tougher financial situation...that's what makes it [their lives] even harder. They think that they'll be in a relationship and they won't have to be on cash assistance...[that] they'll be on their own...but they don't know the reality of it. More than likely they'll be on cash assistance, living in poverty. They'll have a tougher time going to school...makes it hard to go to college and get a degree...Former foster youth as it is have it tough...and then you have another major obstacle of having a child, it's almost impossible. —Program Director*

For social workers there is the added burden of trying to find appropriate placements for teen parents and their child/children. They noted that these placements are often in short supply. While some study participants mentioned having specialized family placements with trained foster parents that mentor the youth and provide parenting support, they struggle to meet the demand for this type of placement.

*I think I would think about it in terms of finding adequate placements... someone that would accommodate a mother and child – not [only] that, but kind of act as a mentor to help them with the parenting. I don't think we have enough quality homes in that respect. —Program manager*

#### 4.5.3. Lack responsibility and accountability among youth

A perceived general lack of responsibility among foster youth with respect to family planning and general health was frustrating to child

welfare professionals. They noted that even if youth receive sexual and reproductive health information and have access to services there is often low birth control utilization and compliance. Additionally, many participants perceived that youth are not willing to be accountable for their reproductive health; they don't want to regularly see a doctor or nurse for STI screenings, contraceptive counseling and basic check-ups. Youth are reluctant to seek care due to lack of comfort during visits with providers. One public health nurse noted that a youth told her, “Ok, I'll get on some kind of birth control, but I don't want to have someone look at me down there.”

*A lot of the young ladies on our caseload, will practice birth control to a certain extent. But they will not practice safe sex, meaning they will not use condoms. That's a big issue. Then, I find that birth control falls off importance, and then they stop taking their birth control method, whether it's the shot or pills, and then they end up pregnant. —Social worker*

#### 4.6. Barriers to addressing youth sexual and reproductive health needs

##### 4.6.1. Sexual and reproductive health topics are difficult to discuss with youth

Nearly all of the study participants mentioned social workers' lack of comfort having sensitive conversations about sexual and reproductive health issues. Many believe that the comfort level with the topic largely influences the nature of the conversations between social workers and youth. With the exception of social workers from specialized units for adolescents, transitioning youth, and/or youth in extended foster care through California Assembly Bill AB12; many social workers were reluctant to discuss such sensitive topics.

**Table 5**  
County policies and policy practices.

	Number of counties (%) (N = 18)
Presence of formal stand-alone sexual and reproductive health policies	
Yes <sup>a</sup>	2 (11%)
No	10 (56%)
Not sure	6 (33%)
Routinely asked to provide information regarding youth sexual and reproductive health in court reports	
Yes	2 (11%)
No	14 (78%)
Not sure	2 (11%)
Collection of sexual and reproductive health outcome data for youth in foster care	
Yes	7 (39%)
No	7 (39%)
Not sure	4 (22%)

<sup>a</sup> Participants from two additional counties responded 'yes' to the presence of a formal policy. The presence of such policies could not be confirmed through the online search or interviews; these responses were adjusted to 'no'.

Some social workers perceived that youth sexual and reproductive health was covered either on a case-by-case basis, or in a likely “superficial...preachy kind of way.” Most thought that many social workers were hesitant to engage youth in meaningful and thoughtful conversations of topics such as healthy relationships, sexuality, and motivations.

*I don't see that we give social workers instructions, or that social workers in general are asking questions that would cause youth to explore...why they might want to have a child, or why they might not want to address birth control...Questions like why they might be having sex with people they don't know well, or that they don't intend to be continuing in a relationship with, or where it doesn't appear that the relationship is going very well, but they're still having...unprotected sex that could lead to disease and pregnancy.—Foster care manager*

Contributing to the lack of comfort among social workers was conflicting personal values and beliefs. Many study participants believed that one's personal biases regarding sexual and reproductive health behaviors might discourage conversations and inappropriately influence youth decisions. Opposing values and beliefs were thought to result in an absence of regular and candid conversations between social workers and youth. A handful of county participants cited the conservative nature of their county as having a potential influence on the discussions that social workers have with youth, and the available resources at the school and community levels. One program director noted that individual personal biases might lead some social workers take a stand in support of abstinence or avoid conversations all together, while other social workers provide a range of information and support.

*I have heard other social workers talking, not in front of kids...talking about [how] they don't believe in birth control, it's against their religion. So, they're not very supportive of that [birth control] for some of the foster youth. I've heard others say things about, they're not comfortable talking about it with the kids, so they don't really do it that much...I think that's something that should be an ongoing conversation. It's a life-changing decision when they [youth in foster care] end up getting pregnant.—Assistant Director*

Trusting and long-lasting relationships with foster youth were identified as a key factor that facilitates conversations with youth about sensitive health topics, future goals, and “the big picture” of their lives. Several study participants perceived that youth might fear repercussions (i.e. loss of privileges or placement changes) if they reveal sexual risk taking behaviors, pregnancy, etc. to their social workers. Participants perceived that youth worried that disclosure of such information could result in exposure of private and confidential information to parents and/or juvenile court judges. Furthermore, the issue of gender discordance between social workers and youth was cited as a barrier to having candid conversations with youth.

*I still believe that to be effective in working with this population, you need to have a working relationship with them [and] they need to trust you...They need to be able to convey to you, without fear of repercussions, these issues. And only at that point would any type of service or intervention be effective. Aside from that, it's like speaking to the wind. It goes in one ear and it comes out the other. And it surfaces and then comes out pretty aggressively.—Foster care supervisor*

#### 4.6.2. Conflicting perceptions of social worker roles and responsibilities

Over half of the study participants indicated that social workers should be primarily responsible for discussing issues of sexual and reproductive health with youth. However, most participants noted that social workers in their respective counties are not mandated to have conversations with youth about their sexual and reproductive health. They are likewise not required to document conversations with youth

in a standardized reporting system or make this information available in court reports. Given the lack of mandates and discomfort discussing sensitive issues with youth there was a perception that discussions of this nature should be left to foster parents or medical providers with more specialized knowledge in the area of sexual and reproductive health, and not necessarily social workers.

*I don't really see the social worker necessarily as the best person to do it, but if we could....we refer them to all kinds of people for all kinds of needs. If there was a way to refer the young person to people who could help them explore their options and make decisions, have good information to make decisions.—Foster care manager*

Some study participants argued that sexual and reproductive health information was and should be covered by medical professionals and/or by community organizations such as Planned Parenthood. Representatives from these organizations were perceived to have greater expertise in this area. Several counties had established linkages with county public health nurses, who provide information, services and support related to youths' general health and issues of sexual and reproductive health. Some participants believed that public health nurses provided a more specialized and accurate source of information for youth. Other participants thought youth were likely to receive necessary information and support from physicians during periodic clinic visits.

*They see the doctor...the assumption would be that the doctor handled that [sexual and reproductive health issues], or the public health nurse handles all of that rather than [social workers] doing any kind of follow up.—Policy manager*

Several participants relied on their ability to refer youth to external community agencies and experts. However, participants noted considerable variability in the frequency, accuracy and accessibility of such sources of information for youth. For example, a large number of participants believed that youth were likely to receive some sexual and reproductive health information through the schools, but they could not detail when youth receive such information, how frequently, or to what extent various topics are covered. While participants from virtually all of the counties believed that the ILP program is a source of information for youth, many cited that not all youth are eligible or able to participate in these sessions due to age restrictions, and other barriers including access (i.e. transportation, time, and foster parent willingness to allow youth to attend such sessions).

#### 4.6.3. Insufficient training in adolescent sexuality and family planning

A barrier to addressing the sexual and reproductive health of foster youth was the lack of mandates stipulating that trainings for social workers and foster parents should occur. In the case of social workers, without a mandate to attend trainings on this topic it was thought that they would not have an incentive to attend due to lack of time and other barriers. While some counties highly support, and in some cases require training for social workers, there is great freedom among staff to only attend trainings that interest them. However, it was noted that social workers have a lot of competing issues and priorities that cause them to overlook the issue of youth sexual and reproductive health if it is not mandated by supervisors and administrators. Child welfare workforce and workload demands were identified as consistent and overarching barriers to addressing this issue with youth in foster care. Budget constraints were additionally cited as a contributing factor to training insufficiencies.

*Every two years they [social workers] are required to complete 40 hours of training...they are not mandated. Some of them [trainings] may be strongly recommended, so it is kind of optional for those who get to go to certain trainings. They can pretty much choose which ones they want to go to. But, I mean, just looking at the various trainings, I don't*



*honestly recall seeing a specific training around pregnancy prevention and STDs.* —Program manager

The lack of sufficient training on the topic of adolescent sexual and reproductive health was seen as an obstacle to social workers comfortably and effectively initiating and facilitating conversations with youth in foster care. As discussed above, there was a sub-set of social workers who were comfortable talking about sensitive issues with youth, but there was an overall perception among study participants that many social workers lacked accurate information about topics related to sexual and reproductive health, particularly birth control options. Participants believed that trainings would help standardized information delivery, stipulate the parameters of what can and cannot be discussed, and increase self-efficacy among those less comfortable discussing sensitive topics. More than one study participant thought that prevention of unplanned pregnancies, teen births, and STIs could be improved if social workers were knowledgeable and comfortable with these topics.

*Some social workers are skilled at that [talking to youth about sexual and reproductive health] and some are not...some foster parents are skilled at that and some are not. A whole lot of us avoid conversations because we don't know what to say.* —Foster care manager

Though lack of training for social workers was largely seen as a barrier in most counties, some study participants noted that their county offered regular trainings for social workers that included topics of sexual and reproductive health. One county noted having “à la carte training” sessions for social workers to help them have difficult conversations with youth in foster care. This county based their training offerings on observed need and staff requests, and cited extended foster care as the impetus for their trainings on sexual health and sexual wellbeing.

#### 4.7. Prioritization of youth sexual and reproductive health needs

##### 4.7.1. Addressing youth sexual and reproductive health is predominantly case-by-case

Some study participants noted that in many cases the delivery of sexual and reproductive health services and resources to youth is not system-wide, but rather prioritized on a case-by-case basis. In lieu of a system-wide approach for all youth in foster care, many social workers described assessing the youth's individual level of risk based on histories of past trauma or abuse, or if a social worker detects current risky behaviors. High-risk youth were prioritized for specific sexual and reproductive health services and support by social workers and external providers. Multiple participants said that in cases of general neglect, it was unlikely that this topic would be prioritized and addressed with youth.

*Depending on the reason for the initial referral...for example if the referral involves a sixteen year old who's having consensual sex with a 17 1/2 year old, of course, sexual and reproductive health would be discussed. If it's not in the emergency response referral, then it [sexual and reproductive health issues] would not be addressed.* —Policy manager

*The only time I would see it as a priority, or the agency would see it as a priority is if for example, a teen pregnancy [was] the product of a rape or crime. Or, if the teen parent has a baby then we evaluate the risk to the baby...If the minor is supposed to be registering with the public health department because they have a certain STD, then at that point it would be a priority.* —Foster care supervisor

When asked to reflect on the extent to which the sexual and reproductive health needs of youth in foster care are met in their respective counties, the vast majority of participants cited considerable room for

improvement in how they handle the needs of foster youth. Some participants specifically noted the necessity for a more comprehensive, rather than superficial approach to youth sexual and reproductive health.

##### 4.7.2. Competing priorities for social workers

For many counties, participants described the sexual and reproductive health needs of youth in foster care as often overshadowed by other fundamental youth needs such as safety, housing, financial resources, employment, and emancipation. One study participant said that youth sexual and reproductive health often doesn't even warrant a conversation by social workers given the many other issues that are believed to take priority.

*I think we start off with education. We always start off with: 'Please graduate from high school.' It's [education] so important; that's number one...I think sexual health and family planning keeps getting pushed down further and further as a priority. Because the question is, will they need housing options, transitional housing, how will they pay for it if they don't get a job, vocational skills, get them to college. That's the push constantly. I don't know of any mandates that say we have to provide sexual health information or family planning.* —Program Supervisor

Some study participants noted that in their county priority was given to behavioral and psychosocial issues possibly related to children and youths' placement in foster care. This often resulted in a focus on behavior modification, counseling and mental health support to ensure youth safety and placement. Also, given limited resources and funding, some counties were only able to focus on “bare necessities” and solely address issues for which there are mandates for compliance. One ILP Coordinator described a practice of having to be “more reactive than proactive,” placing a much smaller emphasis on prevention than they would like.

*The number one go to thing is counseling services...there may be a lack of recognition of a holistic approach. In other words, the emphasis is so much on maintaining or trying to correct behaviors with counseling that basic health care is maybe a lower priority.* —Policy manager

While participants from several counties noted many significant competing priorities, other participants said that social workers should place a greater emphasis on future prevention efforts. As one participant stated, “in all honesty...I don't think it [youth sexual and reproductive health] is given high enough” priority. Participants from some counties said they are beginning to address this issue through the solicitation of grant funding to run prevention programs, hiring of curriculum directors, and formation of committees to provide input on policies and procedures. An unexpected outcome from this study was the comment by several participants that the interview itself had prompted their examination of this issue. Some specifically noted that they would look into their county's possible policies and procedures following the interview.

*As more and more information comes to us about this topic, even just speaking with you [study interviewer], and going to the informational sessions with our partners, I think that we will realize that we do need to make it a priority, and that making a policy is not something that is going to be tremendously hard...we can do that.* —Program Director

Finally, a small number of participants noted that their county is currently allocating considerable department resources (human and financial) to addressing youth needs in this area in terms of assessment, clarification of resources, staff outreach, and curriculum implementation.

*Whatever the kids need, they get. We don't say we are not taking this kid to family planning because [they] need to go to school. I don't know if it is because we have such a big issue, but our adolescents are a priority...if they need educational services they get the educational*

services, tutoring, books, computer...they get family planning, safe sex. —Deputy Director

#### 4.7.3. Barriers to tracking youth sexual and reproductive health outcomes

Some participants thought that prioritization of this issue was linked to data collection systems and outcomes that would by necessity, dictate what type of topics were covered with youth care during routine meetings. The availability of data on youth sexual and reproductive health outcomes would help shed light onto youth needs and areas for improvements. According to one participant, youth participating in ILP complete a program survey regarding program experiences. It was the perception of this participant that the nature of the survey dictates the content of the discussions with social workers, and exemplifies how data can be used to direct programs.

*In the [ILP] survey it's not asking, "Was my reproductive health addressed by the social worker." It is asking..."Did my social worker talk to me about housing? Did my social worker refer me to food stamps? Did my social worker get my medical in place? Did my social worker help me make permanent connections? Did my social worker help with family finding?"...For the social worker when they're completing their surveys throughout the life of the case, they're not asking about reproductive health. —Social worker*

While only a few participants indicated that they tracked sexual and reproductive health outcomes for foster care in their county, none knew the prevalence and/or incidence of outcomes such as pregnancies, teen births, STIs, and abortions. For counties with extremely high teen pregnancy rates among the general adolescent population, there was a sense that issues of teen pregnancy, childbearing, and STIs were likely greater among the foster care population as compared to the overall county teen population. However, they were not certain of the scope or magnitude of various outcomes for youth in foster care in their county because youth are often not aware of what is happening in their bodies, and/or are not willing to disclose their situation to their social workers.

*We're not aware of all of them [foster youth] that are pregnant, [it] is either because they don't know that they're pregnant, [or] they're not reporting to their ongoing social worker...Some of our girls that are runaways, they come back pregnant...when they're about to give birth...We have a number of kids that are runaways...So some of them may be pregnant, some of them may come in the later part of their pregnancy have the baby and then run away again. Every situation is different. —Social worker*

Participants specifically cited that data on youth sexual and reproductive health outcomes are not routinely documented due to youth rights to privacy and confidentiality. They noted that they have to be very careful what information they include in official child welfare reporting systems, as much of this information is documented in court reports. They felt that youth would be hesitant to disclose information for fear of repercussions by social workers, judges and other providers. Participants perceived that youth might fear loss of privileges if they disclosed outcomes to their social workers.

*There are kids that will access a certain clinic and because of confidentiality the clinics will service them and they're not obligated to report certain information...They could be sexually active and if something surfaces, a pregnancy or a disease and then they seek treatment without consent, because they're allowed to do so and the clinics will help them. Those fly under the radar. —Foster care supervisor*

Given the lack of available data and systems for tracking outcomes, participants thought it would be difficult for social workers to have a full sense of the magnitude of sexual and reproductive health issues and challenges in their county. It was suggested that data on youth

outcomes would raise the overall awareness of the issue among child welfare staff and upper management, highlighting the importance and relevance of information, services and support for youth in foster care. In the words of one study participant, "It would force the administration to look at that [issue] and really pay attention."

#### 4.8. Formation of sexual and reproductive health policies

##### 4.8.1. Youth in foster care will benefit from formalized policies

Nearly all study participants identified the potential benefit associated with a formal policy in their county. Participants thought that a policy would add needed clarification to social workers' roles and responsibilities, and provide greater consistency in practice and guidance for discussions. Two issues believed to be particularly confusing for social workers were the questions of youth rights to privacy and confidentiality, and allowable topics for discussion with youth in the work place. It was also thought that a policy would clarify what information can be shared with other providers and included in court reports.

*To have a policy, organizational blessing, direction, would provide consistency and direction and clear guidance for the workers. Generally that encourages them to put themselves [biases] aside and focus more on the child and the child's needs. —Policy manager*

*Social workers did not know if they could even have a conversation with the kids...'Can I have that conversation? Or will I get in trouble for talking about sex? Will I get in trouble for using the word 'penis' and 'vagina' with kids?' So I think they were uncomfortable and afraid of getting in trouble. —Public health nurse*

One participant provided a salient example of how lack of clarity regarding roles and responsibilities, coupled with conflicting values and beliefs among social workers, left considerable ambiguity regarding how to support youth-identified health needs. This example also exemplified the struggle to support youth in the context of complicated legal issues regarding a youth's right to privacy and confidentiality.

*About a month ago...one of our kids who got pregnant for a second time...[and she] wanted an abortion...That became an emergency for us, in a way because then it was like, ok, the foster parents can take her. Well, the foster parent was like, 'No, it's against my beliefs and my values, and you know that won't be right'...They contacted the social worker, and the social worker [said], 'Well I don't know what to do. Can I even take her [to get an abortion]?' Then it turns out the social worker wasn't comfortable...She spoke to the public health nurse in her area who...knows me, super-liberal, would take her...I have no problem transporting her, but we don't have anything telling us that we can or cannot transport...we did speak to a supervisor, and [he/she] said 'Yes, you can transport [a youth] to an abortion but she needs to schedule her own appointment'...It was a lot of uncertain roles and responsibilities...And then we ran into the issue...does she need to document that she was pregnant and she had an abortion...County council said, 'No, that is private and confidential, [and] that does not get documented in any narratives or in court reports.' — Social worker*

Several study participants thought that a formal written policy would be a good opportunity to outline and mandate trainings for social workers, foster parents, and youth in foster care. As noted above, training for social workers on adolescent sexual and reproductive health was viewed as a way to increase the comfort level during discussions between social workers and youth. Topics that they felt should be incorporated into mandated trainings included: healthy relationships, issues for bisexual and transgendered youth, mental and emotional health, safe sex, sexuality education, and guidance on initiating conversations with youth.

*If we had a policy that was across the board...we could train foster parents, we could train incoming social workers, and it could be an ongoing message through our independent living program. That's how I see it could drive home [the prevention message]. That way they [foster youth] get it from all spectrums as they're going through the dependency system. — Social worker*

Study participants from three counties questioned the utility of a formal policy. One county cited the potential challenges of workload increases and the bureaucracy that can be associated with policy implementation. Others cautioned that policies should be carefully developed and framed, in a manner that is thoughtful and not overly prescriptive given the complex nature of this issue.

*When I think of the word policy, I think of labor. And I've been involved in many discussions where, we try to implement things that can be a policy, and it's just a back-and-forth thing. So I think more of implementing good practices, is probably better for us than policy. Because once you try to implement policy, they get dragged out forever. — Program manager*

#### 4.8.2. Policy process relies largely on upper management support and external pressure

Though participants acknowledged potential benefits associated with a formal sexual and reproductive health policy, most noted that their county had not attempted to develop such a policy. Social workers and case managers were more likely to think that policy formation required prioritization by administrators and decision makers responsible for policy change. Most of these individuals did not see a problem raising the issue with upper management, but noted the importance of a champion in the child welfare department to move the issue forward.

Several study participants cited a relatively clear internal process for initiating policy changes that largely involved support and approval from key department leaders, followed by training for social workers responsible for rolling out the new policy. One study participant noted that a state or federal mandate might be necessary to really raise awareness and prioritize this issue, and then it would ultimately trickle down to social workers. Others also saw roles for community organizations and other county agencies such as Planned Parenthood, probation, and public health to instigate the policy formation process.

*You know what, that is actually a question for management, per se. I know that they have their upper management meetings, they meet with the state and they're presented with issues that are really important... things that they want to be implemented in dependency. Then it comes back to your home county, and it gets implemented through our analysts and our...training department...then down to us [social workers]. — Social worker*

Study participants included multiple leaders and decision makers, several of whom had well defined roles in overseeing department procedures. Two participating leaders included deputy/assistant directors for Social Services who shared their approaches to identifying issues of concern. One director discussed the importance of leadership that encourages social workers to bring issues and problems to their attention, and a mechanism for policy change. In her/his opinion, such an “open door policy” by a director was both necessary and likely rare across other larger counties. Key to the model for policy change is acting on the needs and concerns voiced by social workers.

*We have a huge medical marijuana problem...someone came in here the other day and said, 'I really need a policy and procedure on how to assess need do we need trainings?' The social workers are the ones that typically tell me. I also do anonymous surveys...I also have focus groups with staff every year...and I just listen. What are the issues?*

*What do you think needs to be improved here? And that is how I get all of the information I need from them. If I didn't act on it, then I wouldn't be seen in their eyes as a good trusting leader. So when I get information, I actually have to do something...It is more than just listening. — Deputy Director*

A second director formed ad-hoc working groups with volunteers from the child welfare workforce to discuss and update policies as needed. Work group participants ranged from office assistants up to managers, allowing for input from a variety of department stakeholders with a range of roles, responsibilities and perspectives.

*Hierarchical level is not of most importance. What's important is getting an over-arching perspective on every policy we're developing and looking at. So rather than just having the policy department complete a policy when the need comes, we involve the entire workforce, anyone who is willing to be part of these workgroups to flesh the policy out and see it operationalized. — Assist. Director*

Finally, a few counties recognized the role of external advocacy organizations and collaboratives in promoting key policy issues for youth in foster care. One county recounted how an influential youth advocacy collaborative comprised of over 40 foster youth-serving agencies was instrumental in formally recommending that the county address youth sexual and reproductive health (i.e. pregnancy and STI prevention). The county accepted their recommendation, and went on to increase ILP resources and instruction around this topic with input from child welfare staff. Additionally, another county worked closely with a local child advocacy group to form of a county teen pregnancy work group that was charged with developing policies and education strategies aimed at promoting the reproductive health of youth in foster care. Finally, one study participant recounted her involvement in a regional policy committee through the County Welfare Directors Association of California. It was noted that this group of representatives from seven counties regularly discuss a variety of policy issues, and shares new policy ideas. This committee was viewed as helpful in supporting individual and collective policy issues.

*We mostly steal from each other...we share strategies, typically in statutes or codes or regulatory directives, directives of the state, [and] things that affect everybody. Then we do bring up things that are administratively driven, so there's not a statutory requirement for something, but somebody will say, 'Our director wanted this or that – what do you guys have on it.' Or, 'What do you think about this?' We strategize on it [and] how that might work. — Policy manager*

## 5. Discussion

This study sought to examine the content and context of sexual and reproductive health needs, challenges and policies for youth in foster care in California. A policy framework for agenda setting and policymaking was used to guide the data collection and analysis; specifically how problems are defined and available solutions are identified by involvement from multiple policy entrepreneurs operating in varying political environments (Kingdon, 1984; Weissert & Weissert, 2006). Across the participating counties, there was widespread recognition among participants that the issues associated with youth sexual and reproductive health were significant and challenging for both youth and child welfare providers. Similar to findings from other studies, social workers perceived that high workloads and competing demands were significant barriers to addressing this issue with youth in foster care (Polit et al., 1987). Participants used compelling causal stories and descriptive images to exemplify the scope and complexity of youth needs, illustrating challenges associated with access and treatment, insufficient resources and support, and extreme vulnerability (Stone, 1989). The specific youth needs and challenges were

described in the context of the trauma, abuse and neglect that youth in foster care face, placing an added strain on child welfare professionals to sufficiently address this issue.

The majority of participants perceived that social workers were ultimately responsible for making sure that youth had necessary access to information, services and support. Consistent with findings from other studies, participants believed that lack of comfort discussing complex and sensitive sexual and reproductive health topics, conflicting beliefs and values, and insufficient training were barriers to engaging in conversations with youth and providing them with necessary support (Constantine et al., 2009; Knight et al., 2006; Love et al., 2005). Participants similarly used “causal stories” to describe situations where social workers were hesitant to engage in conversations with youth, or unwilling to provide a full range of options and resources given conflicting values and beliefs (Stone, 1989).

The role and influence of personal biases and values among child welfare professionals and foster parents is significant given the potential to limit youths' ability to have candid conversations with adults regarding their sexual and reproductive health needs. According to United Nations Convention on the Rights of the Child, all youth have the “right to express their views, and have them considered, in relation to many walks of life. These include the manner in which they are treated by adults as well as society more generally” (Aggleton & Campbell, 2000, p. 285). This is particularly problematic for foster youth who have limited access to consistent and long-lasting connections to trusted adults, with whom they can receive factual and non-biased sexual and reproductive health information (Constantine et al., 2009; Knight et al., 2006; Robertson, 2013). According to Campbell and Aggleton (1999), youth should not only receive information that is age and culturally appropriate, but they should also be exposed to a range of options that promote risk reduction and prevention strategies. This includes their ability to critically examine how their motivations and behavior are shaped by their own “values, commitments, responsibilities and personal relationships” (Campbell & Aggleton, 1999, p. 250).

## 5.1. Policy solutions

### 5.1.1. Training for social workers and foster parents

Lack of training for child welfare professionals and foster parents on topics related to adolescent sexual and reproductive health was identified as a key barrier to initiating and facilitating sensitive discussions with youth. Findings from this study revealed that few counties provide sexual and reproductive health trainings for social workers. Of the counties that do provide trainings for staff, most participants noted that they do not offer the trainings consistently nor were trainings mandated. Even fewer counties cited trainings for foster parents. As a potential policy solution, participants noted the importance of developing clear policies that stipulate mandatory trainings for social workers, foster parents and youth. Participants largely believed that mandated trainings would provide an incentive to attend the specialized trainings, standardize discussions across the field, define parameters for what content should be discussed with youth, and clarify youth rights to privacy and confidentiality. The trainings were perceived as opportunities for social workers to increase their factual knowledge about adolescent sex, sexuality, relationships, and reproductive health.

The importance and utility of trainings for social workers and foster parents is documented in other studies with child welfare staff (Constantine et al., 2009; Knight et al., 2006; Love et al., 2005), and underscores the importance of including explicit administrative directives and policy provisions that mandate trainings to address issues of sexual and reproductive health with youth in foster care. Formal written policies provide an opportunity to significantly clarify the roles and responsibilities for child welfare professionals and foster parents, stipulate mandatory provider trainings, and outline allowable discussions with youth. The provision of such mandates has the potential to

increase the comfort level during discussions with foster youth and reduce possible misconceptions and biases that often result from insufficient training, and vague policies and procedures.

The lack of available trainings for social workers and foster parents prompted some counties in this study to develop sexual and reproductive health trainings. The outcomes of such trainings are largely unknown given that there are no existing curricula described in the peer-reviewed literature. Despite these shortcomings, Dworsky and Dasgupta (2014) published a report detailing the efforts of the Illinois Department of Children and Family Services in 2013 to mandate the development and implementation of a training to help both social workers and foster parents talk with foster youth about sexual health and pregnancy prevention. An evaluation of the curriculum revealed modest increases in comfort talking about sexual health-related topics. The authors recommended additional topic-specific resources and trainings that include communicating with youth in care, and addressing the needs of youth who identify as LGBTQ (Lesbian, gay, bisexual, transgender, and questioning) (Dworsky & Dasgupta, 2014). While this evaluation was a first attempt to bring greater evidence of social worker and foster parent trainings, more research is needed to better understand the impact of trainings on social workers, foster parents and foster youth.

### 5.1.2. Role of specialized social workers and medical professionals

The lack of comfort discussing sensitive issues with youth, along with insufficient factual knowledge about sexual and reproductive health topics prompted several participants to discuss the role of other specialized social workers and medical professionals in having conversations with foster youth. The perceived lack of capacity and ability to respond to the specific needs of youth in care was believed to be less relevant for social workers from specialized adolescent units who are more accustomed to focusing on the needs of adolescent populations and more capable at engaging in sensitive and complex conversations. Participants minimally discussed the applicability of relying on social workers from specialized units as a policy solution, as some participants mentioned organizational and resource barriers associated with staffing specialized units and in some cases the shift to social workers with general rather than specialized expertise.

Medical professionals such as public health nurses were also believed to be better able to provide youth with appropriate and factual sexual and reproductive health information, services and support, given their technical training and ability to discuss sensitive topics. Participants believed that public health nurses were uniquely positioned to link youth to primary care providers with whom they can discuss confidential health information and services. Nurses were also thought to be able to provide referrals to community-based programs and resources, ensure effective case management, and collaborate with child welfare staff to ensure that youth and foster parents receive necessary education and support (Hudson, 2012; Schneiderman, 2006). Despite the great potential to leverage the skills and expertise of public health nurses, this study demonstrated a scarcity of well-established collaborative models across most counties, thus challenging the widespread feasibility of such a policy solution. Based on the findings from this study it was not possible to determine whether the scarcity of such models resulted from a lack of county resources, or if such partnerships have simply not been developed.

This study revealed that nearly all of the sampled counties utilize referrals to external providers to provide youth with sexual and reproductive health information and support. While the quantitative data do not indicate the degree to which social workers rely on such resources, the qualitative findings suggest a preference for leveraging these resources when social workers are unable to provide support due to lack of comfort and/or time. A potential reliance on external providers overlooks the importance of youth discussing these issues in the context of trusting relationships between caring adults and youth

(Constantine et al., 2009; Haight et al., 2009; Love et al., 2005; Svoboda et al., 2012).

There are significant opportunities for social workers to maintain primary responsibility for ensuring that youth engage in discussions with at least one trusting adult with whom they have a longstanding relationship, while also partnering with external providers. Given appropriate training social workers can have discussions with youth themselves, but also consistently facilitate youth discussions with other individuals that can provide candid information about sex, sexuality, relationships, and family planning. This will require the development of partnerships between child welfare departments and organizations that span multiple sectors (i.e. child welfare, public health, juvenile justice) (Aggleton & Campbell, 2000; Bilchik & Wilson-Simmons, 2010). The development of multi-agency collaborations will necessitate that teams of practitioners work together to overcome existing challenges of varying levels of involvement among stakeholders and poor current collaboration among the multiple agencies that support children and youth in foster care (Schneiderman, Brooks, Facher, & Amis, 2007). Other issues of inter-agency collaboration that must be addressed for successful collaborations include different professional practices, appropriate distribution of roles and responsibilities, protection of youth rights to privacy and confidentiality, allowable parameters for information sharing across agencies, and compatibility with external agencies' agendas and procedures (Frost, Robinson, & Anning, 2005).

Despite potential barriers to multi-agency collaborations these partnerships are critical to helping overwhelmed and uncomfortable child welfare professionals access needed resources and assistance from outside experts that will partner with them to ensure that they are able to more effectively meet the sexual and reproductive health needs of youth in foster care (Bilchik & Wilson-Simmons, 2010; Carpenter et al., 2001). There is a collaborative responsibility to ensure that at least one person assumes primary responsibility for a youth's sexual and reproductive health needs, and that youth have access to a trusted adult with whom they feel comfortable discussing sensitive issues (Knight et al., 2006). With effective collaboration, alliances and partnerships "across professional and lay boundaries and between public, private and non-government agencies," can work to promote effective health promotion (Gillies, 1998, p. 1). How such collaborations can work to most successfully address the sexual and reproductive health needs of youth in care should be examined more thoroughly.

In 2013, California Governor Jerry Brown signed Senate Bill 528 in to law. This bill stipulates that county child welfare agencies are allowed to provide youth in foster care with age appropriate information about their sexual and reproductive health, and to provide youth with linkages to necessary services (John Burton Foundation, 2013). Senate Bill 528 is an important step toward further outlining the parameters for discussions with youth, and clarifying roles and responsibilities for child welfare professionals.

### 5.1.3. Monitoring of youth outcomes

A lack of established systems to monitor and track youth sexual and reproductive health outcomes through child welfare departments, and the inability to access outcome data was pervasive across participating counties. Study participants provided compelling "causal stories" illustrating the issues and challenges faced by youth in foster care, and cited that available data on youth outcomes was lacking and necessary to shed light onto youth needs (Stone, 1989). These findings echo those from the study conducted by Polit et al. (1987), where child welfare professionals noted that they were unsure the degree to which the needs foster youth were being addressed among social workers and across the field, and they were largely unaware of the scope and magnitude of these issues due to non-existent or insufficient tracking of youth outcomes. This current study reinforces the notion that child welfare professionals largely believe that improved tracking and monitoring of foster youth outcomes through child welfare

departments will improve their understanding of youth needs and their ability to meet those needs.

Prior studies cite deficiencies in child welfare reporting systems that document and track the prevalence of pregnancy, live births, abortions, adoptions, and parenting youth in foster care (Constantine et al., 2009; Gotbaum et al., 2005; Krebs & de Castro, 1995; Love et al., 2005). According to Putnam-Hornstein and King (2014), without standardized systems for documenting outcomes across jurisdictions and states, it is difficult to evaluate the efficacy of existing pregnancy prevention programs and determine if programs effectively meet the needs of youth in foster care (Putnam-Hornstein & King, 2014). Many participants from this study believe that the collection of youth sexual and reproductive health data will elevate and prioritize this issue among policy leaders, who they believe are primarily responsible for initiating policy change. The availability of outcome data will similarly make it easier to mobilize necessary resources, generate widespread support for this issue, and demonstrate the impact of policies.

California Senate Bill 528 further mandates that county departments of social services collect data on pregnant and parenting youth in foster care across the state (i.e. number of parenting youth in foster care, youth ethnicity, placement type, county of origin, length of stay in care, and whether or not the child of the dependent parent has been placed in foster care) (John Burton Foundation, 2013). Additionally, the 2014 federal Preventing Sex Trafficking and Strengthening Families Act (H.R. 4980) stipulates improvements to how state child welfare systems track outcomes for children and youth in foster care through the Adoption and Foster Care Analysis and Reporting System (AFCARS). Among the data to be collected are the number of youth in foster care who are pregnant or parenting (Children's Defense Fund's, 2014). Both of these policies will undoubtedly impact the sexual and reproductive health of youth in foster care by providing important data on youth outcomes that will strengthen the information, resources and support that youth in foster care receive.

The collection of youth sexual and reproductive health data should take into account critical issues of youth privacy and confidentiality. While the collection of sensitive data is highly informative to child welfare professionals and policy makers, studies show that privacy and confidentiality concerns among youth in care are barriers to seeking care for STIs and sexual health problems (Hudson, 2012; Jones & Boonstra, 2004; Knight et al., 2006; Lehrer, Pantell, Tebb, & Shafer, 2007). According to Frost et al. (2005) youth in foster care are more likely to have their personal health information shared among care providers and key stakeholders (i.e. child welfare professionals, juvenile court judges and legal council) without their consent. This issue is further complicated by the varying degrees to which providers and stakeholders value and adhere to a youth's right to privacy and confidentiality (Barn & Mantovani, 2007; Frost et al., 2005). As such, developed systems for tracking youth outcomes should be developed carefully and cautiously to ensure youth rights are rigorously maintained, with an emphasis placed on stipulating parameters regarding what outcomes are documented and how information is shared within and among agencies (Lehrer et al., 2007).

As policy mandates regarding the collection of youth data are developed and implemented, the youth perspective will be critical to informing data monitoring systems and data collection practices. Youth should be made aware of why their data are being collected, with whom it will be shared, and how their rights to privacy and confidentiality will be maintained. In the case of highly sensitive data (i.e. STIs and abortions) it will be important to explore the development of alternative (i.e. anonymous and/or community-based) strategies for data collection to help alleviate youths' fears of disclosing sensitive information. Additionally, as county and state-wide data begin to emerge there is an opportunity to elicit input and feedback from foster youth regarding the interpretation and dissemination of findings, to ensure that youth needs and challenges are appropriately conveyed.

#### 5.1.4. Policy formation

Findings from this study demonstrate considerable problem recognition among both local level actors (i.e. social workers and case managers) and central level actors (i.e. child welfare supervisors, administrators, policy leaders) with regard to the perceived impact of sexual risk behaviors, unplanned pregnancies, teen births, and STIs on the health and wellbeing of youth in foster care (Sabatier, 1986; Schofield, 2001). While most participants believed that their county would benefit from a formal policy that clearly documents county policies and procedures, a small number worried that the formation of policies would be too prescriptive and limiting (Polit et al., 1987). Overall these findings are consistent with other studies that have similarly concluded that child welfare staff would benefit from “the establishment of clear, consistent policies and protocols related to their role and practices to promote positive reproductive and sexual health” (Constantine et al., 2009; Love et al., 2005; Max & Paluzzi, 2005; Svoboda et al., 2012, p. 873).

The vast majority of participants in this study were unaware of past or current efforts to develop a policy in their respective county. Only two counties in this study had stand-alone policies that explicitly detailed departmental guidelines and procedures for supporting the sexual and reproductive health of youth in foster care. Substantial barriers to countywide policy formation were cited by participants and included competing mandates, work force demands and lack of prioritization by administrators and policy leaders. Frontline child welfare professionals (i.e. social workers and case managers) believed that the formation of sexual and reproductive health policies for youth in foster care would be difficult, if not impossible, to develop without formal mandates from upper management and decision makers. These central level actors were perceived to be primarily responsible for initiating policy change and providing administrative directives.

A small number of participants who identified themselves as deputy/assistant directors of social services and policy managers (i.e. central level actors) cited mechanisms for social workers to bring critical issues and needs to their attention. While the central level actors described a bottom up approach to policy formation, other participants (i.e. local level actors) did not indicate that they had used such mechanisms to instigate the development of sexual and reproductive health policies or procedures for foster youth. As noted by Polit et al. (1987), even in an environment where there is widespread support for an issue, policy development often fails given that no one takes the responsibility of leading or initiating the policy process. Given that the child welfare system has an organizational culture replete with federal, state, local, and professional mandates it is not surprising that many participants desire a top-down approach to policy formation. This preference is reflective of the policy literature that demonstrates a tendency for policy designers (central level actors) to make policy decisions that lead to well defined legal-mandates that are implemented over time by local level actors (Sabatier, 1986; Schofield, 2001). While there are substantial opportunities for social workers and case managers to bring compelling “causal stories” to the attention of policy leaders and decision makers, findings from this study show that the impetus for policy formation will likely need to come from the willingness of central level actors to prioritize this issue and push the policy process to the forefront of the agenda setting process (Kingdon, 1984; Stone, 2002; Weissert & Weissert, 2006).

#### 5.2. Political policy environment

Participants in this study did not frequently cite traditional factors (i.e. changes in political atmosphere, election results or local government administration) that would indicate the presence of political barriers to policy formation. While participants largely discussed issues of conflicting values and biases, only a few individuals cited the conservative county nature as a limitation to openly and comfortably addressing this sensitive topic with youth in care. Contrary

to these findings, Polit et al. (1987) found that political opposition was the most frequently cited barrier to developing statewide policies to address the sexual development and family planning needs of foster youth. Reasons for political opposition included: the preference among some states to take a “hands off” approach given widespread political opposition to family planning initiatives; the staunch refusal among some social workers and foster parents to discuss these issues with youth; and the controversy around parental rights in favor of parents retaining the right to provide this education (Polit et al., 1987).

Participants from two counties in this study mentioned involvement from prominent foster youth focused advocacy organizations in defining this challenging issue, and advocating for improved services and support for youth. In the county where policy development occurred, multiple child advocacy stakeholder groups pushed the county to increase their focus on reproductive health for youth in foster care, effectively raising this issue to the point of agenda setting. This is consistent with policy theory that suggests that no single policy actor or group of participants has the ability to dominate the agenda setting process, and single handedly direct attention and action to a new issue or problem (Kingdon, 1984; Stone, 2002). The involvement of influential advocacy organizations highlighted in this study suggests the ability of knowledgeable and committed policy entrepreneurs to prioritize sensitive issues either outside of or in collaboration with the child welfare system (Mucciaroni, 1992). Given that policy entrepreneurs can include individuals from multiple sectors, with differing roles and perspectives, they have the potential to promote policy formation in the context of countywide political opposition (Weissert & Weissert, 2006). While participants from this study did not indicate whether the advocacy organizations in the two counties were operating within an opposing political environment, this study still suggests the significant role that advocacy organizations can have in supporting policy formation.

#### 5.3. Impact of extended foster care

Each year, hundreds of adolescents “age out” of the child welfare system leaving many without sufficient resources and safety net systems to support them through their young adult years (Lopez & Allen, 2007). Research with current and former foster youth show that foster youth transitioning to adulthood tend to fare far worse than their counterparts not in care, particularly on outcomes such as education, health, physical and sexual victimization, early pregnancy and childbearing, employment, and homelessness (Courtney & Dworsky, 2006; Courtney, Hook, & Lee, 2010; Dworsky & Courtney, 2010). Given the extensive needs of transitioning age youth, researchers and advocates recommend that youth in care receive extended services from age 18 to 21 to meet their sexual and reproductive health needs, including support for pregnant and parenting youth (Courtney & Dworsky, 2006; Max & Paluzzi, 2005).

The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 is reported to be the most significant and comprehensive child welfare legislation in over 10 years, as it includes a host of new provisions and support systems for foster children and youth beyond age 18 (Bilchik & Wilson-Simmons, 2010). This extended program aims to help foster youth continue to develop permanent connections with caring and committed adults, develop independent living skills while exercising incremental personal responsibility, and provide less restrictive placement options (Child Welfare Information Gateway, 2012). Young adults who participate in this program have a greater opportunity to receive extended support for their sexual health needs from child welfare providers, foster parents, medical professionals, and community providers. By lengthening the period of time that youth receive support, this legislation has the potential to impact sexual and reproductive health outcomes for youth in foster care. For example, the Medicaid program will extend youths' access to health care services, including sexual health screenings and services, and linkages to health

care providers. The long-term impact of this legislation on youth sexual and reproductive health outcomes largely remains unknown. Additional research is necessary to better understand how this legislation will impact youth, child welfare professionals, other care providers, and foster parents.

#### 5.4. Limitations

There are several limitations to this study including the generalizability of the findings. The study includes only a cross sectional snapshot of the content and context of sexual and reproductive health needs, challenges and policies for youth in foster care across a sample of California counties. First, the exclusion of counties with smaller total foster care populations is a limitation as it neglects the perspectives and experiences of smaller counties with potentially different youth needs. Despite findings from conversations with county representatives from counties with smaller foster youth populations that indicated that they do not see enough adolescents to speak to these issues, there are likely counties insights that were lost due to this exclusion. As such, the distinct challenges and solutions of counties with smaller total foster youth populations should be included in future studies.

Second, the exclusion of counties with teen birth rates less than 18 births per 1000 similarly leaves out the perspectives and experiences of counties with smaller countywide teen birth rates. Potentially lost are the lessons learned from counties with a high to moderate total number of children and youth in foster care, but low overall teen birth rates (i.e. San Francisco and San Mateo counties). This may suggest the presence of other important county or community-based programs that may be directly or indirectly supporting the sexual and reproductive health needs of foster youth that should be explored further.

A further limitation to this study was the selection of study participants through snowball sampling, which may have resulted in potential selection bias in favor of those most willing to share their perspectives and participate in the study. Despite these limitations, this study sought to include a diverse sample of county child welfare participants. It is recognized that there is considerable diversity across the counties in California and the full range of child welfare professionals' experiences and perspectives are likely not fully represented in this study.

Finally, the exclusion of youths' perspectives is a significant limitation to this study as their experiences and perspectives should be taken into account when developing policies and procedures that will significantly impact how their needs are addressed. The voice of youth, along with that of foster parents, should be included in future examinations of this topic.

#### 6. Conclusions

The issue of sexual and reproductive health for youth in foster care has significant implications not only for youth themselves but also for child welfare professionals, foster parents, health care providers, and community agencies. Findings from this statewide policy assessment indicate the presence of considerable problem recognition among participating stakeholders with respect to the sexual and reproductive health needs of youth in care. These findings illustrate multiple benefits associated with written policies that clearly outline the provision of care for foster youth provided by child welfare professionals, foster parents and other care providers. These findings demonstrate a shift in perspective among child welfare professionals regarding the utility of policies and possible political barriers hampering policy formation (Polit et al., 1987). In spite of the changing perspectives, social workers still feel uncomfortable talking to youth about sensitive issues (Constantine et al., 2009; Love et al., 2005). Mandated trainings for child welfare professionals and foster parents are a first step toward tackling this issue and ensuring that youth have timely, consistent and unbiased access to information and support to help them make healthy decisions. Given the variations across the sampled counties with respect

to stakeholder perceived policy solutions, each solution should be examined in the context of individual county needs, resources and culture.

The degree to which policy formation is a sufficient solution to address the needs of foster youth remains unknown given the limited number of stand-alone policies in California, and the lack of evidence demonstrating successful youth outcomes associated with policy implementation. Studies are needed to assess the impact of policy implementation from the perspectives of social workers, foster parents and youth to ensure that the sexual and reproductive health rights, needs and challenges of youth in foster care are appropriately met. Though there is evidence from this study indicating that most social workers believe they need a policy mandate to prioritize this issue and change current practices, consideration should be given to the current level of issue prioritization given competing mandates, resource constraints and strategic involvement from influential policy leaders. There is compelling evidence from this study that local level actors (i.e. social workers and case managers) are looking to central level actors to initiate much of the policy development process. Additional support is needed to substantiate the measurable impact of these policies and the degree to which various policy solutions should be implemented across different county settings. As such, it is necessary to develop comprehensive data tracking and monitoring systems that will provide a greater understanding of the scope of unplanned pregnancies, live births, parenting, adoptions, and STIs among young women and men in foster care (Svoboda et al., 2012). The availability of outcome data will also provide additional evidence and new problem framing around this issue that can be helpful to future policy entrepreneurs interested in promoting agenda setting and policy change.

#### Financial disclosures

The author has no financial relationships relevant to this article to disclose.

#### Conflict of interest

The author has no conflicts of interest to disclose.

#### Acknowledgment

Funding for this study was provided by the Kaiser Foundation and the University of California Berkeley School of Public Health. Special thanks go to Ian Bruce, Sylvia Bereknycy and Lisa Chamberlain.

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