

Reproductive Health Education for Foster Youth

INTRODUCTION

One doesn’t have to dig too deep to find evidence that youth in the child welfare system desperately need access to accurate and age-appropriate reproductive health information. Foster youth tend to initiate sexual activity earlier, have greater numbers of sexual partners, and engage in riskier sexual behaviors compared to youth who are not in care (Robertson, 2013). Youth in care and former foster youth experience significantly higher rates of early pregnancy, STDs and STIs, including HIV/AIDS, than do their counterparts in the general population (Courtney, 2009; Robertson, 2013).

The Midwest Study (Courtney, 2009) indicates that only about half of former foster youth use birth control on a regular basis (with only 30% or so using condoms), that three-quarters of the women studied had been pregnant during or since leaving care, and, of those women, two-thirds had experienced more than one pregnancy. What’s more, according to the *Kaiser Family Foundation Fact Sheet: The HIV/AIDS Epidemic in the United States, September 2009*, young adults and teens between 13 and 29 represent 34% of new HIV infections, the largest share of any age group. Presumably, based on the risk factors already associated with foster youth, a considerable number of these youth are current and former foster youth.

Current methods of delivering reproductive/sexual health information to youth in foster care are unsuccessful for a number of reasons:

- Child welfare workers are unsure of their role in this area.

- Foster parents are concerned about causing harm to youth and are reluctant to broach the topic of sex.
- Foster youth may not trust (or have time to develop trust in) their foster parents.
- Foster youth cannot reliably get the information they need from public schools due to being moved from placement to placement.

POTENTIAL SOLUTIONS

A successful reproductive health program for foster youth should be comprehensive and community-based, utilizing expertise and resources from a variety of organizations within a geographic area. Basic characteristics of such a program might include

- Flexibility: it should reach teens wherever they are, in spite of frequent relocation from one placement to another
- Privacy: it should be comprised of confidential *and* group sessions, both of which may contribute to youth becoming more comfortable with their sexual identity and sexual health
- Educational: it should give youth opportunities to become subject matter experts and leaders within the foster youth community
- Diversity: it should not be dependent on overloaded case managers
- Consistency: curriculum should be consistent, and should be mandatory throughout the state of California

Lending further support to this perspective is "The invisibility of adolescent sexual development in foster care: Seriously addressing sexually transmitted infections and access to services," by Roni Diamant Robertson:

Understanding the complex networks of transactions involved in adolescents' access to sexual health services is important in preventing and/or treating STIs/HIV. Conditions that facilitate or impede access to information and services may occur at all levels of the adolescent's ecosystem: macro-, exo-, meso-, and micro-system levels (Bronfenbrenner, 1979). For instance, a youth's decision to seek care could depend on cultural values and norms that adolescents should not be having sex (macrosystem); policies allowing youth to consent to STI testing and treatment (exosystem); community systems interacting with one another on behalf of the youth (mesosystem); and the youth's communication with a parent/ guardian about sexual development (microsystem).

Robertson also calls our attention to the World Health Organization's definition of sexual health: "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." Before moving forward with policy related to the sexual health of foster youth, legislators, child welfare workers and advocates may want to consider adopting this as the official definition (or collaborating to create a definition) in an effort to avoid conflict when actual legislation is on the table.

Once a definition has been accepted, there are a number of potential solutions that will help foster youth get the information and services they need, and if used together the following options, with the exception of Option 1, would allow for a truly comprehensive reproductive health program.

Option 1: Maintain status quo

The current approach relies on public schools to deliver reproductive and sexual health information, budgets permitting, and trusts that someone in the

revolving cast of adults who interact with a youth in foster care will deliver “the sex talk” at some point in the youth’s development. The upside of maintaining the status quo is that the outcome is predictable.

Feasibility and predicted outcome: This option is highly feasible, though it’s important to point out that given the state’s budget issues it is not sustainable in the long run. The state will continue to spend hundreds of millions of dollars per year on medical care for unplanned pregnancies and STDs/STIs among youth in foster care, the long-term consequence of which is more children entering the child welfare system. If President Obama’s proposed budget passes with funds devoted to reproductive health for teens, states will have the opportunity to devote more resources to this issue, but this may result in states pouring more money into minimally effective programs.

Option 2: Social workers to provide reproductive health resources to youth

Legislation proposed in February 2013 (SB 528) would require social workers to ensure that children age 12 or older are informed of their right to consent to and receive reproductive health services. Foster youth are also to be provided with prescribed information regarding reproductive health care. (Additionally, SB 528 will require that the state provide subsidized child-care for foster youth who are parents, ensure these inexperienced parents have access to experts who can help them facilitate a parenting plan, and require the Department of Social Services to collect data regarding the number of foster youth who are also parents.) Currently the law does not stipulate that foster youth are entitled to this information, or that they have a right to seek reproductive health services without

adult consent. Additionally, state and county agencies have very little information about how many foster youth are pregnant and/or parenting; without this data it is impossible to designate appropriate services for this population.

Feasibility and predicted outcome: The bill seems unlikely to pass without more specific definitions regarding the role of the child welfare worker. The language in the bill regarding the provision of reproductive health information is somewhat vague, and one can imagine the new law being handed out to social workers in the form of a memo, which will promptly disappear into the mound of case files and other memos piled on their desks. However, if this section of the bill were to pass, it appears to be a promising starting point for more specific legislation down the road. Child welfare agencies will resist the mandate out of (arguably justifiable) concern over workloads and lack of training and resources. These agencies may initially lack the system needed to carry out the law, but at a minimum the courts will have the responsibility to inquire of youth whether their needs in this area are being met, and to document the outcomes.

Option 3: A 360-degree reproductive health program

Create a reproductive health program using existing resources and ensure foster youth have access to these resources by training all professionals in the youth's life to be comfortable addressing, even at a superficial level, the subject of sexual/reproductive health with youth. This would include dependency court staff, employees of group homes, guidance counselors, social workers, clinic physicians, mental health professionals, and foster parents. The state could partner with Planned Parenthood (or a university) to create a basic training curriculum, which

does not need to cover specific reproductive health information; rather, the curriculum should prepare child welfare professionals to feel comfortable broaching the subject with youth, and then enable them to point the youth to appropriate resources.

Feasibility and predicted outcome: This approach would require that one central agency take responsibility for creating such a program, and doing so will require considerable resources. However, if President Obama's proposed budget passes with significant funds dedicated to reproductive health education, it's possible that such an effort may be entirely funded by the federal government.

While it's difficult to predict how effective this approach would be, presumably the chances of a foster youth encountering the information they need would be greatly increased solely as a result of the increased number of individuals with whom they may have contact and who are qualified to provide the information. Effectiveness should be studied, and doing so could be fairly easy if child welfare agencies begin collecting data about pregnant/parenting foster youth. Anecdotal evidence collected at Edelman's Children's Court in Los Angeles already suggests that court employees are eager to help youth access the information they need, and many career employees are well-situated because they may have long histories with the young people who find themselves in court.

Option 4: Regional centers model for reproductive health/PPT

Expand the Cal-Learn program by creating a county-run support services model focused on reproductive health, pregnancy prevention, and services needed by pregnant and parenting foster youth; structure it as a system in which every child

in care has a right to participate from the moment they enter care. This would be similar to the regional centers model where every prematurely born child and every child with developmental issues is automatically enrolled at birth. The budget for the State of California's 21 regional centers is about \$550 million annually.

Feasibility and predicted outcome: Funding and administration are the main challenges here, but one positive indicator is that regional centers are known to be tremendously successful in assisting children from birth to age 3, suggesting that there are (at least some) elements of the model that are effective. Creating a center the youth has a right to visit is a tremendous project, but an additional consideration is who will ensure the youth actually gets to the center and receives the services offered? And how? A 2006 internal analysis of the Cal-Learn program indicated that workload and communication were the program's two greatest barriers to success; given the state's the current budget situation it's unlikely that circumstances have improved, and even less likely that they will improve without significantly more resources.

Option 6: Mandated private consultations for foster youth

Currently, youth in care are required to undergo a physical exam with a physician once per year, or with every change in placement. The state should go one step further and mandate private consultations between foster youth and primary physicians. Most youth are uncomfortable speaking out about reproductive/sexual health issues in front of foster parents. Foster parents don't need to be privy to these conversations except, perhaps, in extreme circumstances, and even then such knowledge should be at the youth's consent.

Feasibility and predicted outcome: This approach is highly feasible as it simply builds on existing practices; the only additional “work” required would be for case workers and the court to follow up with the youth to make sure they received the private consultations as ordered. It is likely that the physician could be the adult who initiates the reproductive health conversation with the youth, and then a nurse or other trained staff could provide the information and/or access to other resources. The next step in this approach would be to identify when an adult (biological parent, guardian, foster parent, attorney, case worker, etc.) should be notified, for example, if the youth tests positive for HIV, and what the process is for the youth to identify an adult with whom they are willing to share their confidential information. None of this would require a tremendous amount of financial support.

Option 7: Mandatory confidential reproductive health clinic visits

Clinic visits should take place once each year or with every change in placement, for both males and females, from age 12 on. This approach also builds on the existing practice of providing each child in care with regular physical exams, and would require that each child receive reproductive health-focused information from a health care professional in a clinic setting. These visits should take place at the same time as the mandatory physical exam.

Feasibility and predicted outcome: It’s unknown, without further investigation, which clinics currently provide regular exams to foster youth and how many of these clinics are in close proximity to a reproductive health clinic, making logistics a concern. However, California has special funding streams where adolescents, including youth in foster care, can obtain free sexual health services

from community county clinics and non-profit agencies like Planned Parenthood (Robertson, 2013). The cost of birth control and reproductive health information is a factor, but the total expenditure would be significantly lower than that of pregnancy, childbirth, or medical care for youth with HIV/AIDS.

Option 8: Peer-lead vocational training program

States or counties could partner with organizations like Peer Health Exchange to create a vocational training-type program for foster youth who may then develop an interest in the health field. This would give youth the opportunity to be subject matter experts, to reach out to other foster youth in care, and to develop mentoring relationships with staff from the partnering organizations. Reproductive health workshops could potentially take place at SHIELDS for Families, Los Angeles Youth Network, CYC events, group homes, alternative schools, etc.

Feasibility and predicted outcome: This community-based approach may not require substantial additional funding and may extend existing programs with existing agencies whose core competencies lie in outreach to disadvantaged youth. It would require that a central agency take responsibility for planning and executing the partnership. The long and short-term benefit potential of this type of program for foster youth is significant.

FINAL RECOMMENDATIONS

Recent research shows that the state’s current approach to reproductive health among foster youth is minimally effective, and the long-term negative adult outcomes of early/multiple pregnancies and treatment of sexually transmitted

illnesses cost the state of California hundreds of millions of dollars every year (not to mention the intangible costs to the youth themselves).

California is home to a total of about 56,000 foster youth, a little under half of whom are between the ages of 11 and 20. Experts estimate that a single pregnancy without complications (including prenatal care through birth and care immediately thereafter) costs the state between \$5000 and \$7000.

According to research, about 7,500 (30%) of foster youth between the ages of 11 and 20 will become pregnant or father an unwanted child while they're in care. If half of these youth are female, then the research predicts there will be about 3,750 unplanned pregnancies within this population. If each pregnancy costs \$5000, paid for by Medi-Cal, the state can plan to spend about \$18,750,000 on unplanned teen pregnancies.

How much would it cost to deliver age-appropriate reproductive health information to this same population? Planned Parenthood estimates that birth control pills will cost its clients about \$15 per month. If each of those young women in foster care in California (3,750) elects to use birth control, which is paid for by Medi-Cal and costs the State \$180 per year, the total cost to the state would be \$675,000 annually.

If the State of California is able to partner with a cost-effective organization like Planned Parenthood to deliver reproductive health education programs and/or training to individuals and agencies who work with foster youth, the state may be able administer reproductive health education for as little as \$10 per youth, or a total of about \$250,000 annually.

Whether the implementation of SB 528 will be a financial burden is not the only concern legislators have to address. The section of SB 528 that addresses youth having the right to consent to and receive reproductive health information and services appears to be a step in the right direction. However, defining the specific duties of social workers and overcoming resistance posed by child welfare agencies that may view the new law as compounding already insurmountable workloads pose significant challenges to the implementation (and thus effectiveness) of the proposed legislation. The best course of action lies in moving forward with SB 528 and using it as a foundation for more comprehensive and specific legislation, such as Option 3 (a 360-degree child welfare reproductive health program), Option 6 (mandated private doctor visits for foster youth) and Option 8 (peer-lead vocational training program).

Combining these options would create a truly comprehensive reproductive health program for foster youth. At this point in the exploratory process there are no evident trade-offs or reasons to assume that only one of these options is feasible. The program outlined here would ensure that youth get timely, accurate information on a regular basis, have the opportunity to ask questions privately or in a comfortable group setting, experience what it might mean to become a health professional themselves, develop mentor relationships, take responsibility for their own reproductive health, and ultimately experience fewer early pregnancies and STIs. Based on our quick calculations above, the state will benefit by spending fewer tax dollars on unplanned pregnancies among foster youth, the intergenerational

cycle of abuse and neglect that feeds the child welfare system, and on disease-care for citizens with HIV/AIDS.

References

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