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Positive Sexual Health in Nurturing out-of-home Environments

Sexual Health of Foster Youth: Needs Assessment Findings

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The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

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BACKGROUND

Over the past decade, academic research has documented disproportionately high rates of pregnancy among current and former foster youth. It is estimated that females who experience foster care are two to three times more likely to become teen mothers.[1] In Texas, female foster youth are almost five times more likely to become pregnant compared to other Texas teens.[2] However, foster care itself is not the cause of early pregnancy.[3] Rather, a host of risk factors related to trauma and family dysfunction are more likely to drive higher pregnancy rates.

Classroom-based sex education has been the most widely used means of providing sexual health information to youth. For foster youth, little is known about the impact of those programs.[4] Recent discourse suggests that foster youth would benefit from increased sexual health education for adults interfacing with foster youth, as well as through policy and system change.[5] Overall, there is still much more information needed to understand how to best address sexual health among foster youth.

This particular project sought to move beyond the discourse of defining the problems of teen pregnancy and sexually transmitted infections (STIs) among foster youth. Our ultimate purpose is to develop practice resources to address this problem. In this study, we sought to understand how to best intervene with foster youth to promote positive sexual health, including specific information about tools to best engage youth and specific content needed to promote positive and trauma-informed sexual health.

In this study, we conducted a needs assessment guided by the following questions:

1. How are foster youth currently learning about sexual health?

2. What can improve sexual health education for foster youth?

To answer these questions, the research team interviewed five former foster youth, eight providers working with foster youth, and two caregivers to foster youth regarding their experiences and opinions on sexual health promotion for foster youth in Texas. A more detailed methodology is located in the Appendix.

CONTEXTUAL UNDERSTANDING: POSITIONING THIS STUDY IN THE BROADER SEXUAL HEALTH DISCOURSE

Before discussing the findings, we present the reader with our working definitions and understandings of sexual health and foster care. We also present our assumptions so the reader has a lens from which to understand and evaluate our findings.

Sexual health

First and foremost, we define sexual health using the comprehensive definition outlined by the World Health Organization:

"... a state of physical, emotional, mental, and social wellbeing 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[6]

To date, the research on foster care and sexual health has focused almost exclusively on negative health outcomes of sexual activity. Youth in foster care experience higher rates of teen pregnancy and STIs compared to youth who are not in foster care.[7] Multiple regression analyses conducted using National Longitudinal Study of Adolescent Health data from 1994 to 2002 showed that foster youth experienced greater sexual health risk and negative sexual health outcomes compared to non-foster youth. Specifically, this study found that female foster youth were more likely to have sexually transmitted diseases (STDs) and reported increased sexual risk behavior compared to non-foster youth female peers. Male foster youth in that study were more likely to have both gonorrhea and chlamydia but did not report greater sexual risk behaviors compared to non-foster youth male peers.[8]

While these data points are important as they highlight a need for intervention, we contend that the primary focus of interventions should be on sexual health and wellbeing rather than exclusively on the

prevention of negative health outcomes.

Sex positivity

Much of the discourse on sexual health has focused on risk factors for negative sexual health outcomes. Risk factors that have been empirically associated with poor sexual health outcomes (e.g., STI rates and unintended pregnancies) include initiation of sexual activity at or before age 13, high number of sexual partners, and unsafe sex practices, including lack of contraception use and condom use.[9] Other risk factors that impact sexual health behaviors that are most relevant to foster youth include a history of sexual abuse, a history of child maltreatment, and caregiver instability.[10]

Because research has largely focused on identifying rates of negative outcomes and the risk factors that led to those outcomes, sexual health interventions have primarily been developed to reduce the negative outcomes and/or risk factors. The content of interventions is typically steeped in fear-based messaging that tells youth that sex is shameful and dangerous.[11] For youth who have experienced sexual trauma, these messages compound harmful experiences.[12]

We contend that sexual health interventions should be framed from a sex-positive perspective. In its simplest form, we believe this means sexual health should be framed as a positive construct in which youth have information to drive their own decision-making. This study stems from the assumption that youth are in need of comprehensive sexual health information that they do not currently recieve due to the fear and shame-based messaging that permeates most sexual health education.

Social justice

Finally, we believe social justice issues are inherently intertwined with sexual health and wellbeing. For example, early efforts to distribute birth control were largely rooted in eugenics movements targeting women in poverty and women of color.[13] Thus, we believe any use of contraception should be based on the choice of the user rather than societal norms about who makes an appropriate parent.

Additionally, we acknowledge that issues of consent are complex, particularly for youth who have been sexually abused. In theory, every individual has the right to consent to sexual activity. However, in reality, we acknowledge that certain groups have often lacked the ability to consent or not consent to sexual activity, including women, women of color, youth, and non-cisgender individuals. Many of these identities are shared by foster youth, which compounds the need to provide supportive environments to discuss sexual health.

The remainder of this report details key findings regarding sex education provision, the role of caregivers in sexual health conversations, policies impacting sexual health, and recommendations.

EDUCATION REFORMS: CONSISTENT, ACCURATE, AND COMPREHENSIVE SEXUAL HEALTH EDUCATION IS CRITICAL

Research conducted on sexual health education among the general youth population suggests family and school contexts are critical in influencing sexual health behavior.[14] However, foster youth are at a disadvantage to receive sexual health education in these critical contexts as they frequently miss sexual health education in schools due to placement transfers and often do not have consistent caregivers to provide them with accurate sexual health information.

Public schools in Texas are not required to teach any sex or Human Immunodeficiency Virus (HIV) education.[15] If public schools decide to teach sex education, they are required to emphasize abstinence until marriage.[16] Research has shown that increasing emphasis on abstinence education is positively correlated with teen pregnancy and STIs.[17,18] Additionally, there are no content requirements for the sex education curriculum, which allows for medically inaccurate information about contraception to be taught to youth.

In this study, we found two primary themes related to education which align with the prior research described above. First, while existing services and educational opportunities seem comprehensive and beneficial, access for youth in foster care appears to be inconsistent. Second, education should be sex-positive in order to make sexual health education effective.

Inconsistent access to information

Providers and caregivers discussed a variety of educational opportunities and services offered to youth in order to promote sexual health, including case management, peer mentor programs, and group educational activities; some of which are specific to sexual health and some of which are broader.

> *"...we have monthly meet-ups for kids, and they're on different topics. We did one actually a couple months ago on healthy relationships, and that was really good, and I think the kids really benefited from hearing that."*
>
> *– Provider 1*

However, access to these educational opportunities and services seemed inconsistent based on interviews with former foster youth. While some youth learned about sexual health through school-based curricula, caregivers, or medical providers, others were self-reliant or dependent on their peers for this information. In this study, former foster youth shared their ideas on how to provide information to youth in order to help address this gap in accessing information. Three former foster youth expressed the value of peer services and two expressed they would have had an interest in web-based educational tools, such as apps or social media. One former foster youth recommended that education be provided in ways that were more likely to reach youth:

> *"Computer-based training, something that's interactive for them, a podcast. You know, up-to-date videos. A lot of the videos that are still being shown are from the 1990's, the 1980s. So, a lot of it is outdated. So, a lot of current updated videos. Maybe even a social media video from Facebook, or Instagram, or Snapchat just promoting safe sex and healthy relationships. You really don't see that type of stuff anywhere. So, I think that might also be useful in this day and age."*
>
> *– Former Foster Youth 2*

Former foster youth expressed the importance of services and tools about sexual health information being optional and not mandatory. They felt that they were sometimes forced into education settings and would prefer to choose which programs and information best meet their needs.

Educate from a sex-positive perspective with comprehensive information

Former foster youth discussed attitudes from adults and educators that prevent sexual health education from being as effective as it could be. Specifically, they felt that judgment and dishonesty often rendered sexual health education ineffective.

For instance, youth interviewed reported that LGBTQI experiences were not validated within sex education. They suggest that sexual health education should validate their identities and sexuality. Because relatability with a sexual health educator is critical, youth recommended having adults who identify as LGBTQI provide sexual health education.

> *"...this one person keeps coming to mind. So, she was also gay. She was a lesbian. And so, I felt most comfortable talking with her. And she was a minority, so that just made it great."*
>
> *– Former Foster Youth 2*

Both providers and youth reflected on the importance of providing information to youth that is free from shame and fear. Several former foster youth reflected on feelings of shame or fear of judgment related to sex. Providers echoed the importance of sex-positivity in place of shaming behaviors. Former foster youth and some providers reflected that sex-positive information should center on safety, consent, responsibility, and mutual understanding.

> *"I think that it would be really beneficial for us to instead of saying like, 'Don't do this,' teaching our kids like, 'Yes. Sex does feel good. Sex is healthy for us. That's why – I mean, that's why we've had sex how – over however many years that we have been on this earth, and we also need to think of what are the natural consequences... So, we could potentially become pregnant. We could potentially get STDs. We could potentially get STIs.'"*
>
> *– Provider 6*

ALL ADULTS SHARE RESPONSIBILITY FOR SEXUAL HEALTH CONVERSATIONS

As mentioned previously, family and school contexts are critical in influencing sexual health behaviors for youth, but are frequently missed by foster youth.[19] Our interviews with providers and former foster youth suggest there are several challenges that may influence adults talking to youth about sexual health. These include a lack of assumed responsibility, lack of trust, and discomfort.

All adults in child welfare are educators

Adults involved in child welfare systems range from professionals to biological parents. Professionals include child protection workers, case managers, counselors, attorneys, medical providers and judges. Along with professionals, volunteers frequently interact with youth through Court Appointed Special Advocate (CASA) programs and/or other mentoring programs. Volunteers might also include informal mentors such as parents of friends, clergy, and coaches. Caregivers in child welfare tend to be foster parents. However, caregivers may also include direct care staff at institutions, kinship providers, and biological parents.

Despite the large number of adults who are involved in a child's life, participants expressed ambiguity in roles and responsibilities for adults when it comes to sexual health promotion. More specifically, there was no clear sense of whose responsibility it was to discuss sexual health. There were varied responses when the research team asked providers whose responsibility it was to educate youth about sexual health. For instance, some believed it was the caseworker or primary caregiver's responsibility, while many believed it was the responsibility of all adults involved.

> *"So, teachers, parents, caregivers, caseworkers; if everyone recognizes that they have an opportunity to support and has maybe just a brief intervention that they can – or a brief education and resources that they can provide, I think that would be helpful."*
>
> *– Provider 8*

The idea that all adults should be prepared for opportunities to talk with youth is supported by research on trauma and resilience. Studies have shown that relationships heal trauma.[20] Brief interactions of youth with caregivers that are safe and supportive are likely just as important as a formal sexual health intervention. Emerging research on relational permanency suggests that youth in care will develop attachments with adults, depending on the quality of relationships and trust with that adult, who may not necessarily have a formal role in the youth's healthcare decisions.[21] Adults who do not view sexual health education as their shared responsibility allow missed opportunities for youth, leaving them without a clear open door for these conversations. Both youth and providers expressed that all trusted adults involved with foster youth should assume responsibility to engage in conversations about sexual health. This does not mean that all adults need to have this conversation with youth, but rather that youth may gravitate toward different adults. For some, it may be a caregiver. For others, it may be a teacher or therapist. Each adult should provide an open door for youth to engage in these conversations.

> *"I would think it would be all adults' responsibility. Caregivers, therapists, mentors maybe to kind of discuss it. And I say that because certain kids might gravitate towards certain staff or maybe a therapist or a mentor more. So, I would say that if they come or you might be closer to one child and they opened up to you more; you're able to share certain things with them. So, I would say if everybody collectively worked together; that would be a good thing."*
>
> *- Provider 2*

Lack of trust

Lack of trust and rapport between adults and youth poses barriers to sexual health promotion and may stem from issues such as transience of older youth in foster care, high staff turnover, and inconsistent contact with adults. Lack of attachment and role modeling from original caregivers may also play a role.

> *"I think just being provided the information and knowing that if I needed additional support or if I had additional questions, being able to identify at least one supportive or positive adult that I could go to if I needed that information."*
>
> *– Former Foster Youth 3*

Discomfort

Additionally, while some youth prefer group settings for discussing sexual health, they can also pose comfort issues and lack of individualized attention for others.

> *"... you can kind of see certain kids – let's say somebody comes and talks in a group. A child might wait until that person is done to decide, 'Am I going to that person one on one and ask them questions?' because they might not have wanted to ask those questions in that group. So like I said, it depends on the child. If they're more comfortable with one-on-one or if they're comfortable with a group setting."*
>
> *– Provider 2*

Youth and providers suggest an emphasis on consistency in youth-caregiver relationships, including minimizing placement changes, reducing staff and caregiver turnover, and ensuring transition planning or maintaining contact with trusted adults when placement or staff changes do occur. While this recommendation speaks to broader issues in the foster care system, it should be noted that trusted adults can transcend placement changes to ensure youth have a person to talk to about sexual health.

> *"Probably just somebody that didn't leave. I had a CASA at one point. It wasn't the whole time that I was in here. She was really nice, and we did things together and I had kinda had built a trust with her, and then they kinda switched it up on me. But [if I had] just somebody like that from the moment I started in care until the moment I ended, just somebody to grow with me as I was experiencing all this and somebody who didn't have to be through Child Protective Service or anything like that. Just somebody who was older and that just I could confide in too and no matter what placement I was in, like if I moved they'd move with me or they were still like there... that would've been beneficial just to have that consistency."*
>
> *– Former Foster Youth 4*

CONVERSATIONS SHOULD START EARLY AND CONTINUE OFTEN

Interviews with former foster youth and providers suggest that providers and caregivers often waited until a 'crisis' emerged before they engaged in conversations about sexual and reproductive health with youth. Providers and caregivers often consider a crisis to be the discovery of sexual activity among youth, a pregnancy, or a sexually transmitted infection. Once a crisis occurred, adults were more inclined to engage with the youth. However, youth report that the engagement often resulted in adults 'taking control' of the situation by determining what supports/actions the youth needed rather than discussing with youth in a supportive manner. Youth felt they lost autonomy, stability, and even placements due to sexual behavior. One provider acknowledged this issue of the high risk of losing placement due to legal concerns for facilities:

> *"... because if they became pregnant, they were a risk to the facility. They're a liability, and then they had to leave because the facility didn't have a license to care for people who were pregnant."*
>
> *– Provider 7*

Discomfort discussing comprehensive sexual health needs to be addressed

Comfort levels of providers and youth, especially with more historically taboo topics, play an important role in conversations about sexual and reproductive health. There was a wide array of responses — both by providers and former foster youth — regarding their level of comfort in discussing sexual health. While most providers reported feeling comfortable addressing various topics with youth, for some it depended on the topic. For instance, one provider reported less comfort with discussing same-sex relationships, sexual orientation, and gender identity compared to other topics such as contraception. Providers mentioned the importance of establishing clear boundaries with youth when engaging on these topics to ensure youth understand the nature and purpose of the conversation.

Both providers and youth suggested that providers/caregivers needed training and resources to help them talk to youth. Providers asked for trainings on how to engage youth in conversations

that would be more comfortable for youth. Staff turnover was noted as an ongoing issue that might impede efforts to train providers. Thus, one suggestion was to have talking points and ongoing discussions at staff meetings. Another provider suggested tips for brief interventions.

> *"So, maybe even just a few talking points that could be woven into a broader staff training; something that you can pass on really easily to various staff who might turn over frequently. I think it would be really helpful to have something brief and packaged that could be easily transferable."*
>
> *– Provider 8*

Regardless of what training is provided, youth and providers felt that trauma-informed resources were critical. Providers were knowledgeable about trauma and expressed no discomfort in talking with youth about trauma. However, they expressed uncertainty in talking about sexual health and trauma. Thus, training and support are needed for providers.

> *"I think when you're dealing with youth who have experience with sexual trauma or any kind of trauma in general, sometimes it's hard to have those conversations from the caregiver perspective. I think sometimes the training may not be how do we engage in this conversation. Or how do we begin to talk to them about it. It may just be uncomfortable for them. I don't really remember getting in a conversation and talking about it or anything like that."*
>
> *– Former Foster Youth 3*

POLICIES IN FOSTER CARE HAVE TO HONOR YOUTH AUTONOMY AND IDENTITIES

In addition to sexual health interventions and caregivers, study participants identified policies that are harmful to sexual health and wellbeing. Two policies identified in the study are related to birth control and treatment of LGBTQI youth in foster care.

Contraception must be rooted in youth autonomy

When birth control is either prohibited or mandated, it undermines youth autonomy, self-determination, and choice. Foster youth reported some agencies mandated birth control while at placement, which compromised youth autonomy and in turn resulted in youth discontinuing birth control use after exiting care. Providers discussed that the reason for mandated birth control was often due to licensure of facilities that could not be liable to care for pregnancies. One former foster youth also discussed the opposite situation. In her experience, she wanted to take birth control but the placement/provider would not allow it. In both cases, there is a lack of youth autonomy that negatively impacts the perception of birth control and use among youth that has lasting effects on their sexual health.

> *"Yes, when I was placed in care, I was on birth control. And, they wouldn't allow me to continue taking it. I don't know what policy that was. Or, maybe it was the caseworker. She wouldn't allow me to keep taking my birth control."*
>
> *– Former Foster Youth 1*

Sexual health education must include support for LGBTQI youth

Another gap in current sexual health education discussed by former foster youth and providers is the lack of inclusivity and openness of discussing LGBTQI issues and sexuality. Although participants did not specifically mention a policy, they alluded to the lack of support for LGBTQI youth in foster care. Specific policies have recently been passed in Texas that allow providers to claim religious exemptions to not provide sexual health education to foster youth.[22] Former foster youth stated a need for more space and opportunity to discuss these topics in a judgment-free, supportive setting.

> *"Sexuality is already not really talked about as much as it should be. Foster care makes it even harder because they don't have the right people to talk to."*
>
> *– Former Foster Youth 1*

WHAT FORMER FOSTER YOUTH WANT FROM SEXUAL HEALTH EDUCATORS

1. **Validation & Non-judgment**

   Youth and particularly LGBTQIA youth expressed need of validation of their identities and sexuality from educators.

2. **Relatability with Educators**

   Youth discussed having adults who were gay/lesbian or male were valuable to help youth be more comfortable to discuss sexual health topics.

3. **Honesty & Transparency**

   Youth discussed wanting honesty and transparency from adults. Youth felt disingenuous and overly optimistic statements from adults prevent youth from trusting adults.

4. **Consistency of Staff**

   Youth discussed challenges in creating bonds with staff due to high turnover. When staff who had close bonds with foster youth left, it would be difficult for youth to be able to connect with someone else.

RECOMMENDATIONS

Our needs assessment resulted in several themes that provide specific information about how practices and policies can improve sexual health and wellbeing for foster youth. Based on these themes, we make specific recommendations to improve both sexual health education and caregiver supports.

1. Implement trauma-informed, sex-positive, and LGBTQI inclusive sexual health education

First, we recommend that any intervention used with foster youth be trauma-informed, sex-positive, and LGBTQI inclusive. Youth and providers very clearly articulated a need to have honest conversations. Youth specifically want communication to be inclusive of their diverse experiences and gender identities.

2. Improve accessibility & engagement of sexual health education beyond a classroom setting

Given that youth feel that sexual health education was not as accessible to them, our second recommendation is that web-based educational tools be developed for foster youth. Most funding streams for sexual health education require that practitioners use evidence-based teen pregnancy prevention services, which tend to be classroom or group-based programs. Currently, only two of those programs are geared towards foster youth. Therefore, we recommend that sexual health practitioners use alternative strategies for engaging foster youth to increase engagement and accessibility, such as leveraging social media tools and web-based platforms for education informed by the foster youth perspective.

3. Trainings & tools should equip all adults to provide an open-door for sexual health conversations with foster youth

Our third recommendation is that training and tools should be developed for all adults who often interact with foster youth, including professionals, volunteers, and caregivers. Based on our findings, the first step should be to develop training for adults to understand their own values around sexual health and how those values impact their comfort in talking with youth. Next, we recommend that specific tools be developed, such as scripted conversations for providers and volunteers, to practice getting comfortable with the language. We also recommend a toolkit with exercises and handouts, which could be used to facilitate conversations with youth in various ways. Additionally, caregivers should learn about and practice using teachable moments for conversations with youth. Finally, we acknowledge that attending a single training is rarely enough exposure to a topic to ensure that content is translated into practice. Thus, we recommend a web-based learning community where providers and caregivers can obtain additional information and request feedback as needed.

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APPENDIX: METHODOLOGY

Overall design

This needs assessment was conducted using the qualitative methods through interviews with former foster youth and adults (providers and foster parents). This methodology collects qualitative data by interviewing consenting participants based on interview guides developed by the evaluation team and then analyzes data and identifies major themes through content-coding analysis. Two interview guides were developed, one for providers/caregivers and one for former foster youth. These interview guides were developed to ensure consistency, though interviews were implemented in a semi-structured format to allow the interviewer flexibility to pursue particular themes or deeper understanding of responses.

Recruitment & Sample Size

Study participants were recruited from the evaluation team's own network of foster care providers and organizations, in addition to snowball sampling. All participation was voluntary and study participants received a $25 gift card for their time. Interviews and focus groups were conducted either in-person or via telephone between October 2018 to April 2019. Table A1 below provides an overview of the Texas counties, type of interview, and role among providers/caregivers interviewed. All former foster youth were individually interviewed. Among the five former foster youth interviewed, three were from Travis County, one was from Bexar County, and one was from Denton County. A total of 15 people participated in interviews and focus groups for this study.

Table A1. Providers and Caregivers Interviewed

Texas County	Interview or Focus Group	Number of Interviewees	Interviewee Type
Harris	Interview	1	Caregiver
Lubbock	Interview	1	Health Care Provider
Travis	Interview	1	Sexual Health Educator
Travis	Interview	1	Sexual Health Educator
Travis	Interview	1	Court Appointed Special Advocate (CASA)
Travis	Interview	1	Licensed Professional Counselor
Travis	Focus Group	2	Sexual Health Educator
Travis	Interview	1	Foster Parent
Travis	Interview	1	Licensed Professional Counselor

Data Analysis

Interviews were securely recorded and transcribed verbatim by the transcription service GMR Transcription. Transcriptions were analyzed using Dedoose, an online content analysis software. The research team members who participated in the focus groups and interviews developed separate coding schemes for former foster youth interviews and providers/caregivers interviews and focus groups. Each transcript was initially coded by one member of the evaluation team and then another evaluation team member independently coded to ensure consistent application of codes.

When coding was completed, all excerpts and codes were exported to Excel spreadsheets for additional

summarization and organization of themes. Codes were further reviewed to identify quotes that provided good examples of themes.

Limitations

Limitations in the methods exist and should be considered when examining the findings presented in this study. Participation in this study was voluntary and those who participated in the interviews/focus groups could potentially be unique from those that did not participate. Due to small sample size, findings from this study cannot be generalized to the entire population of foster care providers and foster youth in Texas or nationally.

Human Subjects' Protections

Informed consent was obtained from all participants. Interview and focus groups participants provided written informed consent and were offered a copy of the consent form for their records. Every effort was made to maintain the privacy and confidentiality of the participants. Participants were informed of how their privacy and confidentiality will be protected. The identities of interview and focus group participants are known to the UT evaluation team. However, the only record of names is through signatures on consent forms, which are stored in a locked filing cabinet in a secure office. Audio files were transcribed. Audio files were labeled by date and sequence rather than more specific identifying information. Survey participants were asked about their professional background and county. No other potentially identifiable information was recorded. All data results were reported in aggregate form to maintain confidentiality. All digital data will be stored on password and virus protected computers on a secure network for no longer than three years. Access to the network is granted by the principal investigator to study personnel. Only study personnel have access to identified data stored on the secure network.

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