



“We are kind of their parents”: Child welfare workers’ perspective on sexuality education for foster youth

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ABSTRACT

Adolescents and young adults placed in our child welfare system are at an increased risk for pregnancy and sexually transmitted infections due to their likelihood to engage in high-risk behaviors, such as unprotected sex and sex with multiple partners. They receive unclear and inconsistent messages about sexual and reproductive health and lack access to reproductive health services and programs. Focus groups ($N = 3$) comprised of child welfare workers and foster parents were conducted to capture the issues relevant to addressing the sexual reproductive health needs of youth in out-of-home care. Participants indicated that they generally did not receive sufficient training, if any, yet were expected to address sexual reproductive health issues with youth. The responses were organized into three themes that should be considered when developing training interventions: (1) how to communicate with youth about sexual reproductive health; (2) defining adults’ roles and activities in assisting youth; and, (3) discussions about their values about sex and sexual activity. The results of this study point to a need for child welfare workers and foster parents to receive concrete practice skills regarding how to address the sexual reproductive health needs of youth.

1. Introduction

The topic of teen sex is complex, encompassing both joys and significant risks for the youth that have implications for the community as a whole. The consequences of those risks are borne disproportionately by girls, by youth of color, by lesbian, gay, bisexual, transgender, questioning, intersex and asexual (LGBTQIA) youth, by those living in poverty, and by those involved with the child welfare and juvenile justice systems (Ahrens et al., 2010; Carbone, Sawyer, Searle, & Robinson, 2007; Carpenter, Clyman, Davidson, & Steiner, 2001; CDC, 2018; Courtney, Terao, & Bost, 2004; Dworsky & Courtney, 2010; Network, 2017; Matta Oshima, Narendorf, & McMillen, 2013). Teens are at greater risk of sexually transmitted infections because they have more partners (even if they are serially monogamous), and barriers to accessing protection. Half of the new sexually transmitted infections (STIs) reported each year were among youth aged 15–24 (CDC, 2018). In broad surveys of prevalence, there is high risk for all groups of teens: it’s been noted that of the 30% of teens who had sex in the previous 6 months, 46% did not use a condom, 14% did not use any method to prevent pregnancy, 19% had used drugs or alcohol before their last sexual intercourse (CDC, 2018). Queer youth and youth with same sex partners are at greater risk of STIs. In fact, among youth newly

diagnosed with HIV, 81% were gay and bisexual males (CDC, 2018). Teen pregnancy has decreased steeply in recent decades, but still occurs at a high rate. In 2016, 210,000 children were born to teen mothers from age 15–19 (CDC, 2018). Pregnancy has disproportionate effects on girls’ futures versus those of the boys who got them pregnant.

Youth in the child welfare system are at particularly high risk of negative outcomes of sexual risk (Ahrens et al., 2010; Carbone et al., 2007; Carpenter et al., 2001; Courtney, Terao, & Bost, 2004; Dworsky & Courtney, 2010; Network, 2017; Matta Oshima et al., 2013). There were a substantiated 670,000 child victims of abuse or neglect in the US in 2016, a fourth of whom were sexually abused, with the remainder suffering neglect (CWLA, 2018a, 2018b). There were 437,465 US children placed in out-of-home care in 2016 (CWLA, 2018a, 2018b). Both a history of sexual victimization and out-of-home placements are associated with high-risk behaviors, barriers to help, and negative sexual health outcomes such as STIs and unwanted pregnancy (Finigan-Carr, Steward, & Watson, 2018).

Youth face many barriers in communicating effectively about sexual and reproductive health with child welfare workers and foster parents, including: lack of or inconsistency in relationships, placement changes, mental health problems, and developmental needs, according to youth (Svoboda, Shaw, Barth, & Bright, 2012). Inconsistency of family

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support, system disruption of relationships, and higher exposure to domestic violence than their peers (Cunningham & Diversi, 2013) all contribute to lower support, guidance, and service engagement for youth in out-of-home care. Some foster families have been known to actively block discussions of sex due to their religious beliefs (Dale, Watson, Adair, Moy, & Humphris, 2010; Knight, Chase, & Aggleton, 2006).

2. Literature review

2.1. Sexual and reproductive health for child-welfare-involved youth

The literature on sexual and reproductive health risks and protective factors, outcomes, needs, and services for youth in the child welfare system paints a clear picture of elevated risk and points the way toward improved service. In general, youth in out-of-home care have, by definition, a history of inconsistent relationships, childhood trauma, and broken support systems, and many have had numerous placements, depression, exposure to domestic and community violence, and engagement in high-risk behaviors (Network, 2017).

Child-welfare-involved youth have worse sexual and reproductive health outcomes. Girls in foster care are two to two and a half times more likely than their peers to become pregnant (Courtney, Terao, & Bost, 2004; League, 2018a; Dworsky & Courtney, 2010; Polit, Morton, & White, 1989), to give birth (Courtney, Terao, & Bost, 2004); to have more than one pregnancy during adolescence (Courtney, Terao, & Bost, 2004), and to conceive at a younger age (Carpenter et al., 2001). This is true when controlling for maltreatment history, religiosity, school connectedness, or academic achievement, particularly in the years between 17 and 19 (Matta Oshima et al., 2013). In a study of former foster youth who aged out, 43% reported they had been pregnant or got someone pregnant (Collins, Clay, & Ward, 2007). Among young men aging out of foster care, half report having fathered a child, compared to 9–19% of their peers who have fathered children before age 18 (Scott, Steward-Streng, & Manlove, 2012; Svoboda et al., 2012). By age 23 or 24, 77% of women who aged out of foster care had ever been pregnant, versus 40% of their peers (Boonstra, 2011). Not all teen pregnancy is unwanted, and when youth in care are asked about motives for choosing pregnancy (as part of retrospective studies), they have reported a desire to have love and attention, to rewrite their childhoods, and to give the love to a child that they did not receive in their own childhoods (Aparicio, Pecukonis, & O'Neale, 2015; Shannon & Broussard, 2011).

Youth in foster care are also at a greater risk of contracting STIs (Ahrens et al., 2010). In a large quantitative study of children in out-of-home care, two thirds of teens were sexually active, 37.4% were not using any contraception, and over 15% already had an STI (Risley-Curtiss, 1997). Foster youth with multiple psychological and mental health issues are more likely to contract HIV, particularly those with higher externalizing behaviors (Auslander et al., 2002). Factors contributing to this higher STI risk include higher rates of child sexual abuse and sexual assault than their peers, which in turn increases the odds of negative outcomes such as: early sexual debut (Finigan-Carr et al., 2018; Wilson & Widom, 2008); HIV infection (Elze, Auslander, McMillen, Edmond, & Thompson, 2001; Wilson & Widom, 2008); and engaging in transactional sex (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Wilson & Widom, 2008).

Youth who become pregnant while in out-of-home care face incredible challenges, including rapid repeat pregnancy, fear of losing their child to the child welfare system, lower educational attainment, and barriers to parenting resources. Young mothers in out-of-home care are at higher risk for rapid repeat pregnancies (Finigan-Carr et al., 2015). In a qualitative examination of African American teen moms in out-of-home care, parenting served as a motivator for success, but also brought out negative reactions from workers and created a fear of losing their child to the system (Haight, Finet, Bamba, & Helton, 2009).

One study found that 50 percent of participants in a program for pregnant and parenting foster youth ended up dropping out of high school (Dworsky & DeCoursey, 2009). Another study of emancipating foster youth found that pregnant or parenting girls were twice as likely as their peers leaving foster care to drop out of school (Leathers & Testa, 2006). Few pregnant and parenting youth in out-of-home care have taken birthing or parenting classes, despite reports of decent prenatal care (Melby, Rouse, Jordan, & Weems, 2018). In a survey of New York foster care agencies, fewer than half had a training in place for youth on parenting topics or child care (Gotbaum, Sheppard, & Woltman, 2005), although one in six foster girls were pregnant or parenting, and 82% of them cared for their babies. Few youth in out-of-home care who became pregnant report that they learned information about sexual and reproductive health from within the child welfare system, learning instead from school classes, online, and sometimes parents (Melby, Rouse, Jordan & Weems, 2018).

Youth in out-of-home care report less access to sexual and reproductive health services and information (Finigan-Carr et al., 2018). Many times the sexual education arrives too late, due to earlier than average age of first sexual experiences (Becker & Barth, 2000; Boustani, Frazier, Hartley, Meinzer, & Hedemann, 2015; James, Montgomery, & Zhang, 2009; Love, McIntosh, & Tertzakian, 2005). Youth in out-of-home care who were interviewed in depth reported that school-based sex education and confidential communication with primary care doctors were both limited and needed (Hudson, 2012). Often, school is a critical source of information, and school attendance and engagement are lower for child-welfare-involved teens than the average teen, often due to multiple moves (Constantine, Jerman, & Constantine, 2009). For child welfare-involved youth, health risk behavior was predicted by poor school engagement (Leslie et al., 2010). In addition, some youth in religiously affiliated out-of-home care settings are actively blocked from accessing sexual education, services, and resources due to the beliefs of their foster parents or workers (Boonstra, 2011; Constantine et al., 2009; Knight et al., 2006).

Child protection and foster care services themselves carry both risks and protection. Although system-involved youth are at higher risk for negative sexual reproductive health and outcomes, entering the system reduced the risk in a hazard analysis for giving birth before age 18, even after controlling for income (Font, Cancian, & Berger, 2018). Being reunited with family was predictive of higher pregnancy risk compared to youth placed for adoption (Font et al., 2018). Close relationships with caregivers decrease risk of contracting an STI for foster care youth (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013; James et al., 2009). In one quantitative study, although foster youth were more likely to get pregnant, staying in care past age 18 mitigated that risk (Dworsky & Courtney, 2010). Therefore, attributes of the child welfare system itself may not be causal agents.

2.2. Child welfare workers and sexual and reproductive health

Child welfare workers and foster parents face numerous challenges when it comes to addressing the sexual and reproductive health needs of youth in their care. In a study of communication within the worker-youth relationship, foster youth's child welfare workers attribute higher pregnancy and STI risk to mental illness, ambivalence about pregnancy, influence of biological family or peers (Pilgrim, 2012). Foster parents report challenges with communication about sex due to a disconnect between them and youth about gender or sexual orientation, or youth's developmental delays, and describe having limited sexual health knowledge to share (Albertson et al., 2018). Foster parents also express that they cannot monitor youth effectively because they have limited information about youths' past traumas, differing rules in past homes, trouble with targeting communication at the right developmental level for the youth, and not enough resources (Albertson et al., 2018). Qualitative studies of those who work with youth in or at risk of foster care have highlighted the need to acknowledge what youth feel are the

benefits of teen pregnancy and childbearing: proving their worth, as though they were grown, cementing a relationship with their partner, and connecting with their child (Boustani et al., 2015). In a regression analysis, workers' overall comfort with sexual issues was the only significant predictor of increased communication between child welfare workers and foster youth, with age, gender, education and religion having no statistically significant association (Pilgrim, 2012).

Critical to this challenge is workers being unsure of whose responsibility it is to educate youth in care about sexual and reproductive health. Foster parents and caregivers report perceptions that talking about sex was against policy or that they might be accused of abuse (Albertson et al., 2018). Focus groups with child welfare workers reported that there were unclear guidance and policies and inconsistent messages from leadership as to the staff's role in educating youth about sexual and reproductive health (Constantine et al., 2009). This is occurring in a context that is already rife with role conflict, including their professional identity vs. institutional conditions, the demands of relational work vs. paperwork demands, and professional distance vs. supportive closeness in working with children in crisis (Lindahl & Bruhn, 2018). When youth have been asked about this question in qualitative studies, they have asserted that foster parents should provide sexuality education just as any parent should (Dale et al., 2010).

To make systems-level change in reducing pregnancy for youth in care, researchers and advocates recommend a multi-agency approach including public health, juvenile justice, social services, and judges to avoid silos, and to target services and training in the spheres of home, community, school and peer groups (Bilchik & Wilson-Simmons, 2010). Many have called for more and better sexual and reproductive health training for child welfare workers and foster parents (Boonstra, 2011). Although sexuality education trainings have been tailored for youth in care nationally, sexuality education training interventions for child welfare workers and foster parents are being developed and implemented. The objective of the present study is to explore the unique challenges, needs and strengths of child welfare workers and foster parents related to the sexual and reproductive health of the youth in their care in order to build the evidence for intervention development.

3. Method

3.1. Participants

Over a six-month period, child welfare workers and foster parents were enrolled in a one-day in-service intervention training whose objectives were to clarify their roles in preventing pregnancy and sexually transmitted infections among foster youth, train them with regard to serving in this role, and provide them with resources to support foster youth's sexual reproductive health needs. Child welfare workers and foster parents were recruited by the training office of the local child welfare agency to participate in the trainings. All who attended were invited to participate in the focus groups held immediately following the in-service training. Participants were not financially compensated for participation. All participants provided informed written consent. On average, participants were primarily African American women. Child welfare workers had 5–10 years of experience in the field and at least a college degree. Foster parents reported having 1–5 years of experience working with youth in care and less education.

3.2. Procedures

Focus group methodology was chosen as it enabled the research team to understand the context in which the participants worked. Using a semi-structured interview guide, three separate focus groups were held with two different audiences, child welfare workers ($n = 2$) and foster care parents ($n = 1$), following pilot trainings on sexual and reproductive health. Examples of questions asked included: What kind of sexual reproductive health information do you provide to the youth

that you serve? How confident do you feel that you are able to answer youth's questions about sex?

The facilitators were both experienced social workers and researchers supported by graduate research assistants as note takers. Each session included 8–10 participants (40–50% of training participants) and lasted less than one hour (range 45–56 min). Two focus groups were held with child welfare workers and one with foster parents. This was reflective of the types of trainings offered. Sessions were audio-taped and later transcribed for analysis by the graduate research assistants. Transcripts were compared with the audio prior to analysis. The University of Maryland, Baltimore's Institutional Review Board approved this study.

3.3. Analysis

Using a needs assessment framework, this study utilized thematic analysis (Braun & Clarke, 2006) rather than a grounded theory approach to analysis (Strauss & Corbin, 1990). Using NVivo 12 (2018), two authors reviewed the transcripts and open coded them to identify themes that were discussed in consensus meetings. The senior author identified relationships between the open codes (axial coding) and grouped them thematically. Once the codes and themes were finalized, all three authors reread the transcripts and selectively coded any data that related to the core variables identified by the axial coding.

4. Results and discussion

This qualitative research allows for the exploration of the research question posited: what are the unique challenges, needs and strengths of child welfare workers and foster parents related to the sexual and reproductive health of the youth in their care? The information gained from this exploration can be used to develop and improve interventions using what participants viewed as key in creating reproductive and sexual health services for foster care youth. Focus group participants' responses have been organized into three main themes identified as needed in order for them to provide support for the sexual and reproductive health of foster care youth. They are: (1) communication with youth, (2) defining adults' roles and activities in assisting youth, and (3) values about sex and sexual activity. In the next section, the themes are further described with associated codes, sub-codes, and sub-themes.

4.1. Communication with youth

The theme of communication with youth was found across all focus groups and was by far the most discussed issue that should be addressed in future child welfare interventions discussing sexual and reproductive health services. Initially the theme of Communication with Youth started out as a code with the sub-codes of *tailoring communication to fit individual needs of the youth, how and when to initiate communication, and how open and/or comfortable the adult and youth were to having conversations around sexual and reproductive health*. However, due to the frequency of this concept of communication with youth, it became evident to the researchers that a theme was emerging from the data.

Demonstrating the sub-code of *tailoring communication to fit individual needs of the youth*, many participants acknowledged the necessity of this technique with one child welfare worker stating "in my experience you have to deal with it usually [in] a case-by-case situation depending on what arises in the case." Tailoring a conversation included determining what information and education a youth already had about sexual and reproductive health (including factual and incorrect information), identifying what aspects of sexual and reproductive health were most relevant to the youth depending on their current and future levels of sexual activity, and universal sexual health safety precautions. One child welfare worker described this tailoring of a conversation as

“Mainly based on the situation of the case...We were talking about HIV and safety, and just education wise and figuring out where they were...We were just kind of talking to them about what they know, how you can get it in contact, and safety, and what behaviors that they can do to keep themselves safe and to avoid the situation.”

A second sub-code that emerged within the theme of Communication with Youth was *how and when to initiate conversations*. This sub-code was a natural progression from the focus of the training related to participants' roles in preventing pregnancy and sexual transmitted infection in foster youth. Workers and foster parents both reflected that there was no consistency to when they had conversations with youth about sexual and reproductive health. At times workers and foster parents would have conversations in response to questions brought to them by foster youth or when there was evidence that the youth was engaging in sexual activity, such as a diagnosis of a sexually transmitted infection. Another strategy utilized was to have regular conversations with all youth about sexual and reproductive health as described by one child welfare worker supervisor:

“That’s one of the things that I bring up with the youth. We talk about are they sexually active, are they using any kind of birth control. And I encourage my workers when they’re talking with the youths...that [this] is a conversation that they need to be having regularly.”

A third sub-code found under the theme of Communication with Youth was *how open and/or comfortable the adult and youth were to having conversations around sexual and reproductive health*. Both child welfare workers and foster parents readily identified that in order to have effective and meaningful conversations with youth around the topic of sexual and reproductive health, adults have to be comfortable talking about the topic. Participants described being comfortable with the topic as including being knowledgeable of resources and services for youth related to sexual and reproductive health, understanding your own values and “hang-ups” related to the topic, and a baseline trust relationship between the adult and the foster youth. As one foster parent stated, “they come to you confused and have problems...the last social worker or foster parent or whoever didn’t know how to help them and we have been empowered to sort of send them in the right direction.” Two workers also talked about how having sexual and reproductive health conversations, whether they were comfortable or not, was necessary in order to do the job correctly:

“In terms of education of the teens...that can only happen when we’re comfortable in who we are and what our values are because...you’re getting different cases that are transferred to you from different workers. You can kind of see through that [worker’s] already formed an opinion based on what they see...I want to form my own opinions, and I think ...this helps us have a framework to be comfortable in, to sort of be honest with what it is, what our hang-ups are and what stuff we bring to the table. Because I don’t think we can properly service the kids until we’re sure of where we are.”
 “We have almost an obligation to provide resources even if we’re not comfortable in actually having a long drawn out conversation just to at least provide resources or something so that they’re just not in the dark about a lot of things. So as a worker I have a conversation with them. I openly and readily talk to them as long as they’re comfortable.”

Additional quotations found under the theme of Communication with Youth can be found in [Table 1](#).

4.2. Defining adults' roles and activities in assisting youth

The theme of defining adults' roles and activities in assisting youth was also present across all focus groups discussing what issues should be addressed in future child welfare interventions addressing sexual

and reproductive health services. This theme consisted of the sub-themes and codes expressing *workers' and foster parents' perceived roles/duties/values related to their work and strategies to work with youth around the topic of sexual and reproductive health*. Adults in these focus groups talked about their past interactions with youth around the topic of sexual activity, community resources, and changes the adults hope to make in the future with the youth they come in contact with based on those interactions.

The code of *workers' and foster parents' perceived roles/duties/values related to their work* can be very clearly demonstrated by several comments made by adult participants questioning how and in what capacity they are expected to interact with the foster youth around the topic of sexual and reproductive health. One child welfare participant questioned her role because she “used to say, to think to myself, is this appropriate to be having these kind[s] of conversation.” Other adults, both workers and foster parents, identified their role as the source of knowledge and resources for the youth. This was expressed by a foster parent who said “if [the foster youth] comes to me and asks me anything. I have the knowledge to give it to her...that’s why I come to these classes, so that I can have the knowledge for her if she doesn’t know.” Another worker talked about the overlap between personal and professional values along with worker duties and comfort level with the subject material, a concept that was also seen in the previous theme of Communication with Youth:

“If you’re not really comfortable with dealing with a teen who might have values that you don’t have, then you’re less likely to talk, or less likely to have that discussion with them because [you’re] not comfortable with going there. ...And I think one of the good things is knowing that you don’t have to answer your personal, but just give them the option of where to find the information that they might need even if you don’t have it. So, you’re feeling comfortable enough to let them know ‘okay, I may not have this information, but we can look it up on the internet or find resources.’”

Another aspect of the sub-theme *workers' and foster parents' perceived roles/duties/values related to their work* that emerged related to the role of parenting from a worker perspective when engaging foster youth. Most child welfare worker participants that discussed the issue of parenting acknowledged that whether it is in their job description or not, they are expected to act in a parenting capacity at times with the youth they work with in foster care. How this role of parenting manifests in interactions with youth, though, seems to be up to interpretation depending on the worker. One worker described this role as a substitute parent: “In foster care...the workers sort of take on this parental type of relationship and feel... I’m this substitute parent... but when it comes to sexuality, and that type of thing...I’m basically this resource person.” Another worker noted that if she did not discuss the topic of sexual and reproductive health then there was no other person in the foster youth’s life who would: “We are kind of their parents. Their parents aren’t involved. Their biological parents aren’t involved. I think it’s kind of our job to have conversations with them about sex, and if we aren’t doing it, who else will?” It was also noted that the role of parenting changes depending on the classification of the worker with some child welfare departments essentially writing parenting into the job description as one worker described in the difference between in-home and out-of-home job expectations:

“I’m in in-home service, with family preservation. So you have parents that are there that are supposed to be providing that sort of information. So you have to watch the boundaries of where you stop because it’s not like the thing where it’s out-of-home, where you are the co-guardian.”

The other code found within the theme of Defining Adults' Roles and Activities in Assisting Youth was *strategies to work with youth around the topic of sexual and reproductive health*. As the focus groups for this research study were held with child welfare workers and foster parents

Table 1
Themes, sub-themes and example quotations.

Theme	Sub-Themes	Quote
Communication with Youth	Tailoring communication to fit individual needs of the youth	"In my experience you have to deal with it usually [in] a case-by-case situation depending on what arises in the case." [Child Welfare Worker]
	Tailoring communication to fit individual needs of the youth	"Mainly based on the situation of the case..., we were talking about HIV and safety, and just education wise and figuring out where they were...we were just kind of talking to them about what they know, how you can get in contact, and safety, and what behaviors that they can do to keep themselves safe and to avoid the situation." [Child Welfare Worker]
	How open and/or comfortable the adult and youth were to having conversations around sexual and reproductive health	"Explaining to [youth] instead of over exaggerating or getting upset with them, talk to them more calmly and try to make them feel as comfortable as possible because you don't know what they're going through. Also remember that it's hard for them to come and ask you those questions." [Foster Parent]
	Communication with youth	"They come to you confused and have problems, they don't know which way to turn or anything like that. That last social worker or foster parent or whoever didn't know how to help them and we have been empowered to sort of send them in the right direction." [Foster Parent]
	How and when to initiate communication	"That's one of the things that I bring up with the youth, we talk about are they sexually active, are they using any kind of birth control. And I encourage my workers when they're talking with the youths...that is a conversation that they need to be having regularly." [Child Welfare Worker]
	How open and/or comfortable the adult and youth were to having conversations around sexual and reproductive health	"In terms of education of the teens...that can only happen when we're comfortable in who we are and what our values are because...you're getting different cases that are transferred to you from different workers, you can kind of see through that [worker's] already formed an opinion based on what they see...I want to form my opinions, and I think that trainings like this help us have a framework to be comfortable in, to sort of be honest with what it is what our hang-ups are and what stuff we bring to the table. Because I don't think we can properly service the kids until we're sure of where we are." [Child Welfare Worker]
	Communication with youth	"[they are] scared that you're going to put them out because they want to talk about having sex or uncomfortable with their body...they don't want you to punish them...they just want to feel comfortable so they can continue to have that trust in you." [Foster Parent]
Defining Adults' Roles and Activities in Assisting Youth	How open and/or comfortable the adult and youth were to having conversations around sexual and reproductive health	"We have almost an obligation to provide resources even if we're not comfortable in actually having a long drawn out conversation just to at least provide resources or something so that they're just not in the dark about a lot of things. So as a worker I have a conversation with them, I openly and readily talk to them as long as they're comfortable." [Child Welfare Worker]
	Workers' and foster parents' perceived roles/duties/values related to their work	"used to say, to think to myself, is this appropriate to be having these kind[s] of conversation." [Child Welfare Worker]
	Strategies to work with youth around the topic of sexual and reproductive health	"I think this training helps in taking the negative stigma that's attached to sex when it comes to discussion about talking about sex...Um, I believe that if we have had more positive conversation with our youths surrounding sex, then I mean, you wouldn't see I guess the amount of teenage pregnancy that you do see...When you think about our teens, you think about the trauma that they face, and the fact that they're here due to a negative situation. Everything just looks negative to some degree to the majority of them, and when it comes to them saying 'I'm having sex' even that is being view[ed] from a negative perspective. I do realize that there were times when I did shut that door...when I could have used a different method that would have kept it open and allowed me to be more effective." [Child Welfare Worker]
	Workers' and foster parents' perceived roles/duties/values related to their work	"If you're not really comfortable with dealing with a teen who might have values that you don't have, then you're less likely to talk, or less likely to have that discussion with them because [you're] not comfortable with going there...And I think one of the good things is knowing that you don't have to answer your personal, but just given them the option of where to find the information that they might need even if you don't have it. So you're feeling comfortable enough to let them know 'okay, I may not have this information, but we can look it up on the internet or find resources.'" [Child Welfare Worker]
	Strategies to work with youth around the topic of sexual and reproductive health	"I need not to impose myself into the conversation as much...I need to open up the floor and allow them to tell me what is specifically going on with their situation...each child, each situation is different so give them what it is they're looking for...not so much [things] that are said, but what is reason made behind why they're asking the question." [Child Welfare Worker]
	Strategies to work with youth around the topic of sexual and reproductive health	"...I will offer an example...'this happened to me,' or 'this happened to my friend,'...oftentimes I try to...find something that's similar to what's going on at hand, so I can try to make them feel a little bit more normal about what's going on." [Child Welfare Worker]
	Strategies to work with youth around the topic of sexual and reproductive health	"I definitely talk to them, um, even if they put off the image as if they're not sexually active...I still always go back to 'well if you decide to, make sure you talk with me or talk with someone and always protect yourself because it's, you're not, you don't have to just worry about, um, being pregnant but there's also STDs and AIDS out here so make sure you protect yourself always." [Child Welfare Worker]

(continued on next page)

Table 1 (continued)

Theme	Sub-Themes	Quote
Values about Sex and Sexual Activity	Strategies to work with youth around the topic of sexual and reproductive health	“It’s just good to know information in general about the STDs and where they can go to get help if they don’t feel that they can trust you, that’s a foster parent, where they can go and get their information so they can be treated and be put back on the right path. [Foster Parent]
	Strategies to work with youth around the topic of sexual and reproductive health	“You need that consistent support. Once you know that the child [has] a problem, and you do get assistance from your workers but you need consistent support, especially if you’re a foster parent at work or something like that.” [Foster Parent]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“If [the foster youth] comes to me and asks me anything, I have the knowledge to give it to her...that’s why I comes to these classes, so that I can have the knowledge for her if she doesn’t know.” [Foster Parent]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“when we interject ourselves into people lives it’s always been, uh, historically or most people perceive that it’s always in a negative fashion, um, and we’re not open to giving information so having trainings like this where you’re, where you’re able to learn correct and factual information and having snapshots in the handouts and things that we’ve bene provided really helps us to be able to better engage our community.” [Child Welfare Worker]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“Maybe the kids just aren’t educate[ed] about sex and reproductive and stuff like that and nobody’s addressing it, and they’re sitting in care and they’re jumping from group home to this home to that home to that home and stuff like that is not being addressed.” [Child Welfare Worker]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“in foster care...the workers sort of, they do take on this parental type of relationship and feel, with these kids...I’m this substitute parent,...but when it comes to sexuality, and that type of thing, I, then I’m basically this resource person, is that my misunderstanding? [Child Welfare Worker]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“I’m in in-home service, with family preservation, so you have parents that are there that are supposed to be providing that sort of information, so you have to watch the boundaries of where you stop because it’s not like the thing where it’s out-of-home, where you are the co-guardian.” [Child Welfare Worker]
	Workers’ and foster parents’ perceived roles/duties/values related to their work	“We are kind of their parents, their parents aren’t involved, their biological parents aren’t involved. I think it’s kind of our job to have conversations with them about sex, and if we aren’t doing it, who else will?” [Child Welfare Worker]
	LGBTQIA youth and/or same sex partners	“as workers we can’t fear it...it is prevalent so we have to either talk about or be comfortable finding resources to send our kids to some resources or someone who is comfortable in talking about it.” [Child Welfare Worker]
	“Putting their values on the children”	“Workers tend to want to put their values on the children or they admonish them about you know what they should or should not be doing, the way they should or should not be feeling...and I have that concern a lot, that sometimes ‘cause people don’t feel comfortable they will revert back to talking about what they do personally.” [Child Welfare Worker]
LGBTQIA youth and/or same sex partners	“I have a client and the foster mother tells me that this client of mine is exhibit [ing] lesbian lifestyle, my value system is not there, so when I go visit my client I have to put that face on to speak to her and do my work, do my job. Even though the foster parent will say ‘Can you just tell her, tell her no?’ Well I put that face on and tell [the foster parent] why you can’t tell [the youth] no.” [Child Welfare Worker]	
LGBTQIA youth and/or some same sex partners	“My unit got a transgender male, and how we had to kind of change his appearance for his safety, because as we know there is like very limited resources as far as placement, out-of-home placement, for those types of children...so the regular group home for males kept him for a short time... because they were concerned about how the other boys were going to react to him...the main reason he came into care [was] because it was starting to be a safety issue for the foster parents because she didn’t know how to handle him because she said strange men were knocking on her door during all times of night looking for him.” [Child Welfare Worker]	
Sexually active	“I took him to his first physical and it turned out he had Chlamydia. So we talked about it and it was the main thing my husband said...he said no love no glove, that’s what he would tell the boys and they thought that was funny, but we really got them into using condoms and that was a good thing.” [Child Welfare Worker]	
Sexually active & “Putting their values on the children”	“My staff have a majority of teens, and the teens that have, that are sexually acting out, and being very provocative, now we try to teach them, with regards to being safe. But it’s really, it’s a hard balancing act to try to really get into it, because regarding their behaviors it’s just, myself I don’t approve of it, so it makes it kind of hard because I feel it’s risk taking behavior and promiscuity.” [Child Welfare Worker]	

after a one-day training on pregnancy and sexually transmitted infection prevention in foster youth, the most frequent strategy identified was education and training. Participants noted that they felt more comfortable and confident working with foster youth around the topic of sexual and reproductive health after receiving up to date

comprehensive information. One worker noted that not only does education impact work with foster youth; it also impacts the overall community’s view of child welfare:

“When we interject ourselves into people lives it’s always been uh

historically or most people perceive that it's always in a negative fashion um and we're not open to giving information. So having trainings like this where you're able to learn correct and factual information and having snapshots in the handouts and things that we've been provided really helps us to be able to better engage our community."

For foster parents, this strategy of education and training was also related to the trust they build with the youth in their care:

"It's just good to know information in general about the STDs and where they can go to get help if they don't feel that they can trust you that's a foster parent, where they can go and get their information so they can be treated and be put back on the right path."

Utilizing clinical principles and techniques was another strategy identified, this time by just the child welfare workers. One of the clinical principles mentioned was meeting a client where they are as demonstrated by a worker who said they "need not to impose myself into the conversation as much...I need to open up the floor and allow them to tell me what is specifically going on with their situation." Another worker used the clinical technique of normalizing as a strategy:

"I will offer an example ... 'this happened to me,' or 'this happened to my friend,' ... oftentimes I try to ... find something that's similar to what's going on at hand, so I can try to make them feel a little bit more normal about what's going on."

Additional quotations found under the theme of Defining Adults' Roles and Activities in Assisting Youth can be found in [Table 1](#).

4.3. Values about sex and sexual activity

The theme of values about sex and sexual activity is comprised of many personal reflections from participants. This theme encompassed the codes *LGBTQIA youth and/or same sex partners*, *sexually active*, and "putting their values on the children." In the previous theme of Defining Adults' Roles and Activities in Assisting Youth, the code *workers' and foster parents' perceived roles/duties/values related to their work* also dealt with the concept of adult values. For the current theme Values about Sex and Sexual Activity, the code of "putting their values on the children" relates to the more personal values the participants had about sexual and reproductive activity, not work values. Similar to the patterns seen in the previous themes, values about sex and sexual activity found participants' considering their actions in the context of what is best for the youth. It is important to note that most quotes related to this theme came from the child welfare workers as this group delved more into the LGBTQIA issues and youth who are currently sexually active than the foster parents.

For the code *LGBTQIA youth and/or same sex partners*, there was a wide range of comments across the spectrum of acceptance to rejection of foster youth due to the youths' identification with this population. One child welfare worker who endorsed the acceptance end of the spectrum, stated that in regards to same sex activity "as workers we can't fear it...it is prevalent so we have to either talk about or be comfortable finding resources to send our kids to some resources or someone who is comfortable in talking about it." Another child welfare worker pointed out system wide lack of knowledge regarding transgender youth needs and safety concerns for a transgender male youth on his/her caseload. In this particular case, not only was the worker worried about being ill equipped to deal with the needs of the youth, but so were the group homes and foster parents working with the transgender child. The worker noted, "we had to kind of change his appearance for his safety, because as we know there is like very limited resources as far as placement, out-of-home placement, for those type of children." Unfortunately, the worker identified that the youth came into out-of-home services because the youth's foster parents did not feel like they could handle safety concerns related to the youth's sexual

orientation and sexual risk behaviors.

Participants repeatedly brought up issues when working with LGBTQIA youth including lack of knowledge, being uncomfortable talking with youth, unsure of resources, and concerns about safety. One child welfare worker noted that she and the youth's foster mother both struggled with dealing with a youth:

"I have a client and the foster mother tells me that this client of mine is exhibit[ing a] lesbian lifestyle. My value system is not there, so when I go visit my client I have to put that face on to speak to her and do my work, do my job. Even though the foster parent will say 'Can you just tell her, tell her no?' Well I put that face on and tell [the foster parent] why you can't tell [the youth] no."

Similarly, the concept of safety was also seen in the code *sexually active*. Workers discussed how they brought up safe sex practices with youth in an effort to reduce disease transmission and pregnancies. Some workers also mentioned that youth are hesitant to admit to being sexually active or there are pre-conceived ideas from workers about whether a youth is engaging in sexual activity. Therefore, workers discussed how applying universal education about safe sex practices could be a key technique in working with youth. One child welfare worker, who was also a foster parent, talked about how she changed her approach to talking about sex after one of her foster youth who indicated that he had not engaged in any sexual activity ended up with an STI:

"I took him to his first physical and it turned out he had Chlamydia. So we talked about it and it was the main thing my husband said ... He said no love no glove, that's what he would tell the boys and they thought that was funny, but we really got them into using condoms and that was a good thing."

At times, there was an overlap between the codes *sexually active* and *putting their values on the children* as workers struggled to incorporate their own personal beliefs with the actions and beliefs of the foster youth. One worker reflected on how her and her team struggle with concerns for youth who engage in sexual activity:

"My staff have a majority of teens, and the teens that have, that are sexually acting out, and being very provocative, now we try to teach them, with regards to being safe. But it's really, it's a hard balancing act to try to really get into it, because regarding their behaviors it's just, myself I don't approve of it. So it makes it kind of hard because I feel it's risk taking behavior and promiscuity."

The code of "putting their values on the children" was further seen when child welfare workers reflected on their own actions and those of colleagues that did not display sex positivity or acceptance of decisions and behaviors of foster youth. In these instances, workers took an authoritarian role with youth they viewed as going against the workers' own personal values as demonstrated by the following quote:

"Workers tend to want to put their values on the children or they admonish them about you know what they should or should not be doing the way they should or should not be feeling ... and I have that concern a lot that sometimes cause people don't feel comfortable they will revert back to talking about what they do personally."

Additional quotations found under the theme of Values about Sex and Sexual Activity can be found in [Table 1](#).

The results from the current study support earlier work which found that barriers to having conversations with providers around meaningful topics exist for a multitude of reasons including inconsistent relationships with trusted adult which can lead to negative service engagement and support later for system involved youth (Cunningham & Diversi, 2013; Svoboda et al., 2012). Clearly, the individual provider (i.e. child welfare worker or foster parent) plays a pivotal role in not only supporting foster youth as a trusted adult, but also as a source of

knowledge, insight, and stability in an otherwise changing landscape. However, providers are limited in their ability to provide these needed emotional supports to foster care youth, despite research demonstrating much greater youth outcomes when providers take on an advocacy or attached role outside of their general job descriptions (Lindahl & Bruhn, 2018). These barriers, as indicated by the current study and previous research, include unclear messages about whose responsibility it is to educate youth and fear of consequences for discussing sex with youth in care (Albertson et al., 2018; Constantine et al., 2009).

4.4. Recommendations/future directions

Across all themes found in this data, participants identified key items and concepts needed in improving their responses to the sexual and reproductive health needs of foster care youth. These key items and concepts can further be used for future interventions and trainings targeted to child welfare worker and foster parents. Participants in this study identified that communication is a major technique for addressing the sexual and reproductive health of foster youth. Furthermore, within communication the participants talked about how they struggled with their own personal comfort levels related to having conversations about sexual and reproductive health. Participants also talked about their confusion on how and when to initiate communication with youth. Future intervention trainings should outline the importance of communication skills for adults working with youth in child welfare, as well as provide skill development lessons.

Participants identified having a clear definition of the adults' role when assisting foster youth as a key item when developing future interventions and trainings. Within role definition participants asked for a better understanding of how duties and values, both professional and personal, impact sexual and reproductive health services to foster youth. This role definition is an administrative solution child welfare organizations can provide to both workers and foster parents so those individuals have guidance on how best to serve the foster youth. Participants also indicated that having strategies on how to work with youth around the topic of sexual and reproductive health was very important. Future interventions and trainings for this population should include clear and direct strategies that child welfare workers and foster parents can utilize immediately after learning.

Participants in the current study also identified values about sex and sexual activity as a potential barrier to providing sexual and reproductive health services to foster youth. Within the concept of values, participants discussed LGBTQIA youth and same sex partners as well as the idea that some workers put their own values on foster youth, which can result in youth being judged harshly if their values do not match that of the worker. Overwhelmingly child welfare workers and foster parents expressed a need for more information and training around LGBTQIA youth including safety concerns, unique service and emotional needs, and agency/worker response to youth who identify with the LGBTQIA population. Based on the response from participants in this study about their lack of knowledge on the topic of LGBTQIA youth, it is recommended that any future intervention and training discussing the topic of foster youth should include a section about working with LGBTQIA youth.

Within just the child welfare worker focus groups, the concept of putting your own values on foster youth was also discussed as related to values about sex and sexual activity. Workers identified the negative aspects of putting your own values on youth including lack of understanding where the youth are coming from, inability to build relationships with youth, and reprimands to the youth from workers when values do not match. Participants acknowledge that putting their values on foster youth was not ideal but they also struggled with how to overcome what they saw as a natural tendency. Moving forward future trainings and interventions must include overcoming personal value based judgment and response into their curriculums for workers in an effort to create more engaging relationships between foster youth and

workers.

In addition to the above key items and barriers to future trainings and interventions for child welfare workers and foster parents, a few more concrete needs were identified from this study. Participants asked for specific practice examples and reported needing more skill based trainings to enhance their work with foster youth around the topic of sexual and reproductive health. Participants discussed how not enough of the youths' voices are heard during trainings and future trainings should include opportunities for youth panels so youth can express their needs in their own words. Participants suggested administrative solutions such as youth education, youth skills training, youth parenting groups, digital content, peer education program, life skills assessment upon coming into care, and more specialized units within child welfare agencies (e.g. teen unit, resource unit with parenting groups, and LGBTQIA unit).

5. Strengths and limitations

It must be acknowledged that there are strengths as well as limitations to the current study. The study sample was relatively small. Participation was voluntary and it was a convenience sample of participants from pilot trainings on the sexual and reproductive health of foster youth. This may lead to potential bias and limit the generalizability of the findings. However, the sample reflected the demographics of the population of both foster parents and child welfare workers in the urban child welfare agency. Generalizability is also limited due to the qualitative methodology employed. The aim of this methodology is to provide a complete, detailed description of the phenomena, in this case, related to the needs of child welfare workers and foster parents and the sexual reproductive health of foster youth. As this is an exploratory study, generalizability was not expected.

Additionally, two of the focus groups were of child welfare workers and one was of foster parents. This was a limitation related to the pilot intervention trainings offered. Although the themes were similar, future research should include more focus groups overall as well as equal groups of both. One last limitation is related to the focus group facilitators and authors themselves. All of the facilitators and authors have been child welfare workers or foster parents. In addition, the facilitators including the senior author were African American women similar to the majority of the participants. As a result, there may be bias due to their position in relation to the child welfare workers and foster parents who participated in the focus groups. Interview guides for the focus groups and multiple coders of the resulting transcripts were utilized in order to enhance the study's rigor and minimize any biases.

6. Conclusion

Child welfare workers and foster parents could benefit from interventions that address how to engage foster youth about their sexual reproductive health. They see a need for training to address the sexual reproductive health of youth in care, including how to communicate with each other about foster youths' sexual reproductive health needs. Implementation of such interventions could lead to prevention of unintended pregnancies and the incidence of sexually transmitted infections, as well as to improvements of youths' overall well-being. These interventions should include the provision of practice skills for effective conversations with youth about sexual reproductive health behaviors.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://>

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