CARING FOR CHILD WELFARE-INVOLVED YOUTH:

Evaluating a sexual and reproductive health training for court professionals working with youth in foster care

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Purpose

This report explores the beliefs, self-efficacy, barriers, and needs of a variety of court-related personnel regarding their roles in sexual and reproductive health care for foster youth before and after a sexual and reproductive health training session.

Background

In 2017, California passed Senate Bill 89 (SB 89), which requires caseworkers (including social workers and probation officers working with foster youth) to do the following: (1) create normalcy around sexual and reproductive health for foster youth; (2) ensure foster youth 10 and older receive age-appropriate, medically accurate information about sexual and reproductive health on at least an annual basis; (3) ask foster youth if they are facing barriers to any desired sexual and reproductive health services; (4) ensure any barriers to sexual and reproductive health services faced by foster youth are addressed in a timely and efficient manner; and (5) facilitate transportation to any sexual and reproductive health services requested by foster youth. SB 89 also requires judges and attorneys who work with youth in foster care to ensure child welfare agencies are meeting the aforementioned five requirements.

In addition, SB 89 mandates that certain professionals, including judicial officers and caseworkers, receive training on sexual and reproductive health for youth in foster care. SB 89 requires this training to include information on the following: (1) foster youth's rights to sexual and reproductive health information and services, (2) professionals' obligations to ensure foster youth can obtain sexual and reproductive health information and services as described above, (3) requirements for documenting sexual and reproductive health information, (4) communicating with youth about sexual and reproductive health, and (5) sexual and

reproductive health referral resources. This report describes the evaluation of a training designed to meet these requirements.

Methods

Training and sample

We developed an in-person sexual and reproductive health training for a variety of court professionals who work with youth in the foster care system, including judges; attorneys who represent children, parents, and/or agencies; social workers, including court officers and intake and detention control personnel; probation officers; and Court-Appointed Special Advocates, among others. The content of the training meets the requirements of SB 89 as described above. Training sessions ranged from one to three hours in length. Because of the limited time allotted for the training, it was provided primarily in lecture form, using case studies, and did not include practicum.

The training was initially piloted between March and May 2018 with court professionals at four sites throughout California. These trainings were sponsored by the Judicial Council of California and provided as part of the implementation of SB 89. Participants represented both urban and rural counties as well as large and small counties. Feedback from participants at these four sessions was used to make iterative changes to the training materials. The final version was then presented to court professionals at eight training sessions in Los Angeles County between July and October 2018. Data from these eight trainings are included in this evaluation as described below.

Data collection and instrument

Participants completed surveys immediately before and after the training session. The pre-training survey included two questions about participants' roles and responsibilities related to sexual and reproductive health for foster youth. It also included two questions assessing participants' beliefs and self-efficacy regarding their role in supporting sexual and reproductive health for foster youth and one question about barriers to sexual health conversations with foster clients. The post-training survey contained the same four questions about beliefs, self-efficacy, and barriers, but not the questions about roles and responsibilities. The post-training survey also contained two questions about participants' needs and recommendations for further support regarding sexual and reproductive health for foster youth.

Analysis

Beliefs, self-efficacy, barriers, and needs were assessed using frequencies and descriptive statistics. Pre- to post-survey changes in response frequencies for repeated questions were evaluated using McNemar's test. Only data from participants who completed both pre- and post-training surveys are included in the analysis for each item.

Results

Participants' roles and responsibilities

Two-hundred fifteen court professionals participated in both pre- and post-training surveys and are included in these analyses. As shown in Table 1, the most common roles represented in the analyses are social worker (including court officers and intake and detention control personnel; 32%) and child's attorney (22%). Ten participants (5%) indicated they had two or more roles,

TABLE 1. PARTICIPANTS' ROLES (N = 215).

Role	n	%
Social worker (includes court officers and intake and detention control personnel)	69	32%
Child's attorney	47	22%
Probation officer	34	16%
Investigator	20	9%
Court-Appointed Special Advocate	8	4%
County counsel	1	<1%
Other	34	16%
No answer	12	5%

The majority of participants (84%) indicated they had at least one legal responsibility related to sexual and reproductive health for youth in foster care, and 67% reported having more than one responsibility (see Table 2). The most commonly reported responsibilities were asking youth about barriers to sexual health care (65%), ensuring youth are provided with information about sexual and reproductive health (64%), and ensuring barriers to sexual and reproductive health services are addressed (62%). The frequencies of other reported responsibilities are summarized in Table 2, and the frequencies of reported responsibilities by role are detailed in Table 3.

TABLE 2. PARTICIPANTS' LEGAL RESPONSIBILITIES RELATED TO SEXUAL AND REPRODUCTIVE HEALTH FOR YOUTH IN FOSTER CARE.

Responsibility	n	%
Asking foster youth if they are facing barriers to health care, including desired sexual and reproductive health conditions and services	139	65%
Ensuring foster youth 10 and older are provided with age-appropriate, medically accurate information about sexual and reproductive health care at least annually	138	64%
Ensuring barriers to desired sexual and reproductive health services are/were addressed	133	62%
Creating normalcy to support the healthy sexual development of youth	127	59%
Facilitating transportation to sexual and reproductive health services requested by foster youth	81	38%
No answer	35	16%

TABLE 3. PARTICIPANTS' LEGAL RESPONSIBILITIES BY ROLE.

	Role					
Responsibility	Social worker (n = 69)	Attorney* (n = 48)	Probation officer (n = 34)	Investigator (n = 20)	CASA** (n = 8)	Other (n = 34)
Asking foster youth if they are facing barriers to health care, including desired sexual and reproductive health conditions and services	61%	85%	74%	20%	25%	53%
Ensuring foster youth 10 and older are provided with age-appropriate, medically accurate information about sexual and reproductive health care at least annually	61%	71%	94%	40%	38%	65%
Ensuring barriers to desired sexual and reproductive health services are/were addressed	49%	81%	74%	45%	38%	65%
Creating normalcy to support the healthy sexual development of youth	51%	60%	74%	55%	63%	65%
Facilitating transportation to sexual and reproductive health services requested by foster youth	33%	38%	65%	20%	0	34%
No answer	19%	8%	6%	15%	38%	18%

*Includes child's attorneys and county counsel

**Court-Appointed Special Advocate

Beliefs and self-efficacy

Ninety percent of participants (n = 195) responded to both pre- and post-training questions about their belief as to whether compliance with state laws is likely to impact sexual and reproductive health for youth (see Table 4). Of these 195 participants, 87% agreed or strongly agreed with the statement "Compliance with state law will make an impact on sexual/reproductive health outcomes for youth in foster care" prior to training; 95% agreed or strongly agreed after training. The proportion of participants who strongly agreed increased significantly from pre- (42%) to post-training (64%), p <0.001.

TABLE 4. PARTICIPANTS' BELIEFS ABOUT THE STATEMENT "COMPLIANCE WITH STATE LAW WILL MAKE AN IMPACT ON SEXUAL/REPRODUCTIVE HEALTH OUTCOMES FOR YOUTH IN FOSTER CARE" (N = 195).

	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)
Pre-training	81 (42%)	87 (45%)	20 (10%)	5 (2.6%)	2 (1%)
Post-training	124 (64%)***	63 (32%)	7 (4%)	0	1 (<1%)

****p*-value for pre-training to post-training change is <0.001

Ninety percent of participants (n = 194) also responded to both pre- and post-training questions about their preparedness to meet state legal requirements regarding sexual and reproductive health for foster youth (see Table 5). Prior to training, only 42% of participants agreed or strongly agreed with the statement "I have been provided with all the resources and knowledge that I need in order to meet the requirements of state law in my work." After training, a large majority (91%) agreed or strongly agreed with the statement. The proportion of participants who strongly agreed increased significantly from 13% to 45%, p < 0.001.

TABLE 5. PARTICIPANTS' RESPONSES TO THE STATEMENT "I HAVE BEEN PROVIDED WITH ALL THE RESOURCES AND KNOWLEDGE THAT I NEED IN ORDER TO MEET THE REQUIREMENTS OF STATE LAW IN MY WORK" (N = 194).

	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)
Pre-training	25 (13%)	57 (29%)	77 (40%)	28 (14%)	7 (4%)
Post-training	88 (45%)***	90 (46%)	15 (8%)	1 (<1%)	0

****p*-value for pre-training to post-training change is <0.001

Barriers and needs

Participants were asked to select from a list of potential reasons they may be hesitant to have conversations about sexual health with youth. Participants were able to select all applicable options. Prior to training, the majority of participants (78%) reported one or more of the potential barriers to conversation listed (see Table 6). The proportion of participants who reported one or more barriers decreased significantly post-training to 69%, p = 0.008. The most frequent responses pre-training were: not knowing teen clients very well (43%), being unsure as to whether they are supposed to be talking with youth about sex (20%), and the perception that talking about sex is not appropriate given the participants' role (19%). As shown in Table 6, the proportion of participants who endorsed five specific perceived barriers decreased significantly post-training. Notably, "I am not sure if I am supposed to be talking with youth about sex" was the second-most commonly reported barrier prior to training but rarely reported (5% of participants) after training.

TABLE 6. REASONS PARTICIPANTS MAY BE HESITANT TO HAVE CONVERSATIONS ABOUT SEXUAL HEALTH WITH YOUTH IN THEIR WORK.

Response	Pre n (%)	Post n (%)	*p*
It is difficult when I don't know the teen very well	94 (43%)	64 (29%)	<0.001
I am not sure I am supposed to be talking with youth about sex	43 (20%)	11 (5%)	<0.001
It is not appropriate given the role I play	40 (19%)	24 (11%)	0.002
It is difficult when the teen is a different gender than me	33 (15%)	24 (11%)	0.049
I don't think I have up-to-date sexual health information	29 (13%)	16 (7%)	0.019
I'm afraid of an allegation or complaint against me	29 (13%)	24 (11%)	0.297
I don't want to encourage teens to have sex	14 (7%)	18 (8%)	0.317
It is difficult when the teen has a different sexual orientation than me	10 (5%)	9 (4%)	0.796
There is a generation gap and I can't relate to what some youth say	10 (5%)	7 (3%)	0.317
It conflicts with my legal obligations	9 (4%)	5 (2%)	0.206
It conflicts with my morals, values, or religious beliefs	8 (4%)	12 (6%)	0.206
Other	24 (11%)	31 (14%)	0.178
No answer	47 (22%)	66 (31%)	0.008

Participants were also asked to select all that applied to them from a list of potential additional resources, knowledge, and/or training that would help ensure their ability to meet the sexual and reproductive health needs of foster youth. Eighty-nine percent of participants (n = 192) identified at least one area of need. As shown in Table 7, the most frequent responses were information about referral resources and services in the community (66%) and support around how to effectively communicate with youth regarding sexual health (63%).

TABLE 7. OTHER RESOURCES, KNOWLEDGE, AND/OR TRAINING THAT WOULD HELP ENSURE PARTICIPANTS' ABILITY TO MEET THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF FOSTER YOUTH.

Response	n	%
Information about referral resources and services in the community	141	66%
Support around how to effectively communicate with youth regarding sexual health	136	63%
Information about legal obligations and rights	107	50%
Information about sexual health and "healthy sexual development"	102	47%
Information about the barriers to care that foster youth face	99	46%
Other	10	5%
None of the above	23	11%

Lastly, after training, participants were asked to provide short free-text answers to the question "What else can the child welfare system do to address unintended pregnancy and support healthy sexual development of youth in foster care?" Sixty-five participants provided responses. Responses frequently included recommendations for continuing or improving sexual and reproductive health education for foster youth (n = 21), foster caregivers (n = 6), and professionals who work with foster youth, such as social workers and attorneys (n = 6). Other common recommendations included providing professionals and/or foster youth with printed information, such as pamphlets, about sexual and reproductive health (n = 5), integrating sexual health services with child welfare services by providing mobile sexual and reproductive health care at sites such as court or a child's attorney's office (n = 3), and developing and implementing programming to connect foster youth with adult mentors (n = 3).

Limitations of the Evaluation

This evaluation was limited by the relative homogeneity in the types of professionals included in the analysis. Further evaluation of judges and other roles not commonly represented in this

assessment (including Court-Appointed Special Advocates and county counsel) would provide more robust information on the training's effectiveness among a variety of professionals. Furthermore, due to time constraints of the participants, trainers were unable collect data on participant demographics, such as age, gender identity, or race/ethnicity. Future training evaluations might benefit from assessing relationships between demographic characteristics and training outcomes. Additionally, this evaluation assessed participants' beliefs and self-efficacy immediately after training only; further study is needed to determine whether the training has long-term effects on attendees' beliefs, self-efficacy, or behaviors. Lastly, the most rigorous way to evaluate the effects of this training would be to compare outcomes among court professionals who participate the training to outcomes among a control group of professionals who have not yet completed the training.

Discussion and Conclusions

The trainings included in this evaluation were primarily attended by social workers (including court officers and intake and detention control personnel), attorneys, and probation officers. Most participants endorsed having multiple responsibilities related to sexual and reproductive health for youth in foster care. Notably, although social workers and probation officers who work with foster youth are legally required to perform all of the duties queried, prior to the training, none of the five duties was universally reported as a legal responsibility by social workers or probation officers. These findings suggest a need to provide social workers and probation officers with clear and specific information about their legal responsibilities under SB 89. Additionally, further evaluation of this training would benefit from querying participants' perceptions of their responsibilities both before and after training to assess whether the session improves participants' understanding of their legal obligations. Per SB 89, attorneys are not directly responsible for the duties listed but are required to ensure child welfare agencies are meeting these obligations; that a majority of attorneys indicated responsibility for four of the five requirements suggests many attorneys are aware of their responsibility to provide oversight and ensure these requirements are met. Additionally, many participants who do not have legal obligations related to sexual and reproductive health under SB 89, including investigators and Court-Appointed Special Advocates, nonetheless frequently endorsed having legal responsibilities to support the sexual and reproductive health of foster youth. This finding suggests many court professionals demonstrate commitment to supporting the sexual and reproductive health of foster youth even when they have no legal obligation to do so. Overall, an

obligation to create normalcy around sexual and reproductive health was commonly endorsed by participants in all roles, suggesting many court professionals perceive speaking openly about sexual and reproductive health topics with youth in foster care as an important role for professionals who work with foster youth. Of note is that facilitating transportation to sexual and reproductive health services requested by foster youth was the responsibility endorsed least frequently by social workers and probation officers as well as attorneys, suggesting a significant need to ensure court professionals are aware of this requirement in particular.

Completion of the training was associated with a significant increase in the proportion of participants who believe compliance with state law will make an impact on sexual/reproductive health outcomes for youth in foster care. Training completion was also associated with a significant increase in the proportion who felt they had been provided with all the resources and knowledge needed to meet the requirements of state law in their work.

After training, participants were significantly less likely to report hesitation to have conversations about sexual health with youth in their work; in particular, the proportions of participants who endorsed uncertainty as to whether they are supposed to talk with foster youth about sex, who felt talking about sex with foster youth was not appropriate given their role, and who felt they did not have adequate information about sexual health decreased significantly. However, most participants reported one or more areas of need related to sexual and reproductive health for foster youth after the training. Of note is that each of the areas of need commonly reported after training – including information about referral resources and services in the community, legal obligations and rights, sexual health, and healthy sexual development as well as strategies for communicating with youth about sexual and reproductive health and addressing related barriers – was included in the training session to some extent, indicating a need for more in-depth training on these topics. This suggests that court professionals would benefit from longer and/or multi-session trainings, the inclusion of practicum, and more specific case studies. Lastly, officers would likely also benefit from ongoing opportunities to discuss their questions and needs with policy experts as well as experts in adolescent sexual and reproductive health.

We recommend, if possible given time and financial constraints, continued evaluation of this training, including assessment of the training's long-term effects on knowledge, attitudes, and behavior. Further evaluation would ideally be done in comparison to a control group that has not yet participated in the training.