CARING FOR CHILD WELFARE-INVOLVED YOUTH:

Evaluating a sexual and reproductive health training for healthcare providers working with youth in foster care

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Purpose

This report explores healthcare providers' knowledge, attitudes, and self-efficacy around sexual and reproductive health care for foster youth before and after a three-hour training session. A multi-disciplinary team of medical providers, social workers, and attorneys with the Los Angeles Reproductive Health Equity Project for Foster Youth (LA RHEP) developed the training with input from youth in foster care. Specific content areas included (1) health disparities among youth in foster care; (2) practical tools and guidance for providing foster-friendly care; and (3) confidentiality, consent, and reporting laws related to treating youth in foster care.

Methods

Training and sample

We conducted two three-hour in-person training sessions for a total of 75 healthcare providers in May 2018. Participants included healthcare providers who care for foster youth at medical "Hub" clinics in Los Angeles County, California. Hub clinics are affiliated with the Los Angeles County Department of Health Services and devoted exclusively to the evaluation and ongoing management of health for youth in foster care.

Data collection and instrument

Participants completed a written 21-item survey before and again immediately after the training. Surveys contained seven multiple choice and three true/false questions designed to assess participants' **knowledge** of the training material. Surveys also included five questions assessing participants' **attitudes** about providing sexual and reproductive health care for youth in foster care and six questions assessing **self-efficacy** related to providing this type of care. The evaluation was reviewed by the Seattle Children's Institutional Review Board and determined to be exempt.

Analysis

Knowledge, attitudes, and self-efficacy before and after the training were summarized using frequencies and descriptive statistics. Changes in knowledge (the proportion of correct responses) after the training were evaluated using paired t-tests. Changes in attitudes (proportions of responses) were evaluated using McNemar's test. Self-efficacy responses were converted to numeric scores on a five-point scale, from 1 (strongly disagree) to 5 (strongly agree). Mean pre- and post-training scores for each self-efficacy item were calculated and compared using paired t-tests. Only complete pre- and post-training pairs are included in the analysis for each item.

Results

Participants

Sixty healthcare providers participated in both pre- and post-training surveys and are included in these analyses.

Knowledge

As shown in Table 1, participants' knowledge increased significantly on the cumulative/overall score and for six of ten specific items. The largest increase (45%) was in knowing who to notify if a foster youth reports they have been raped or sexually assaulted, followed by knowing that laws do not prohibit social welfare workers from discussing sexual health practices with youth (+28%), knowing current and former foster youth are eligible for MediCal until age 26 if they had an open case as of their 18th birthday (+27%), knowing most foster youth who become pregnant do not do so intentionally (+23%), and knowing providers are able to share foster youth's sexual and reproductive health information with child welfare workers only if the youth has signed a medical release authorization (+23%).

Participants' knowledge did not change significantly for four items (see Table 1), likely due to high levels of knowledge pre-training. Pre-training knowledge was high for questions related to the prevalence of pregnancy among youth in foster care (87% of participants answered correctly pre-training), the prevalence of adverse childhood experiences among foster youth (100% correct pre-training), and whether minors may consent to sexual and reproductive healthcare services in California (97% correct pre-training) and remained high after training. Only 45% of participants

were able to correctly identify all appropriate responses from a list of potential questions to ask when taking a sexual and reproductive health history from foster youth both before and after training.

Overall knowledge increased significantly from a mean of 57% of questions correct on pre-training surveys to a mean of 73% of questions correct on post-training surveys, $p < 0.001$. Mean knowledge also increased significantly for each content domain (see Table 2). The pre- to post-training increase in the mean proportion of questions correct was highest for the confidentiality, consent, and reporting laws domain. After training, knowledge was highest for questions related to health disparities among youth in foster care and lower for questions related to providing foster-friendly care and confidentiality, consent, and reporting laws.

TABLE 1. PROPORTION OF PARTICIPANTS WHO ANSWERED SPECIFIC KNOWLEDGE QUESTIONS CORRECTLY BEFORE AND AFTER TRAINING.

Knowledge question	Answer	Pre-training % correct	Post-training % correct	Change	*p*
If a foster youth under my medical care reports to me that they have been raped or sexually assaulted, I should immediately notify:	Child Protective Services (CPS)	17%	62%	+45%	<0.001
Which is not a factor contributing to high rates of unintended pregnancy among foster youth in the state of California?	Laws prohibiting social welfare workers from discussing sexual health practices with youth	42%	70%	+28%	<0.001
Current and past foster youth are eligible for MediCal:	Until the age of 26 if they had an open case as of their 18th birthday	60%	87%	+27%	<0.001
True or false: Most foster youth who become pregnant do so intentionally.	False	70%	93%	+23%	<0.001
A caseworker and attorney for a foster youth under your care requests you to share the youth's sexual and reproductive health information. You are:	Able to share the information if you have a signed medical release authorization from the youth on file	30%	53%	+23%	0.002

TABLE 1 (CONTINUED)

Knowledge question	Answer	Pre-training % correct	Post-training % correct	Change	*p*
When parental involvement is not believed to be harmful, guardians have a right to be informed about the following treatment received by youth in their care:	Emergency and sexual assault	18%	37%	+19%	0.011
True or false: Nearly half of foster youth have been pregnant at least once by the age of 19.	True	87%	92%	+5%	0.159
Which of the following are appropriate questions to ask when taking a sexual and reproductive health history from a foster youth? Check all that apply.	*Multiple*	45%	45%	0	
True or false: In the state of California, all minors 12 and older are legally allowed to consent to sexual health services without parental notification.	True	97%	97%	0	
Compared to non-foster youth, teens in foster care are:	At higher risk of experiencing one or more negative reproductive health problems as a result of adverse childhood experiences	100%	98%	-2%	0.321
Overall		57%	73%	+16%	<0.001

TABLE 2. PROPORTION OF PARTICIPANTS WHO ANSWERED SPECIFIC KNOWLEDGE QUESTIONS CORRECTLY BY CONTENT DOMAIN.

Domain	Pre-training % correct	Post-training % correct	Change	*p*
Confidentiality, consent, and reporting laws	40%	62%	+22%	<0.001
Health disparities among youth in foster care	75%	88%	+13%	<0.001
Providing foster-friendly care	53%	66%	+13%	0.004

Attitudes

Participants' pre- and post-training responses to questions assessing their attitudes about sexual and reproductive health services for foster youth are summarized in Table 3.

All participants agreed or strongly agreed with the statement "By screening for adverse childhood experiences, I can be better informed about the different health risk behaviors foster youth may be engaged in" before training; after training, 98% of participants agreed or strongly agreed with the statement, while 1 participant (2%) was neutral. The proportion of participants who strongly agreed increased significantly from 64% pre-training to 84% post-training, $p = 0.007$.

The majority of participants disagreed or strongly disagreed that "informing youth in the foster system about contraceptive options is only marginally helpful in reducing pregnancies because most foster youth want to become pregnant," both before (79%) and after (85%) training. The proportion of participants who strongly disagreed increased significantly from pre- (34%) to post-training (59%), $p = 0.002$.

All participants agreed or strongly agreed with the statement "By fostering a positive relationship with my patient in foster care, I can increase the likelihood that they will feel comfortable talking about sensitive information with me," both before and after training. There was no significant difference in the proportions of participants who strongly agreed with the statement before and after training.

Prior to training, 88% of participants agreed or strongly agreed that providers "should ensure youth choose the most efficacious contraceptive that is safe for the youth to use, irrespective of historical reproductive coercion that may influence youth's perceptions of long-acting reversible contraceptives." After training, the proportion of participants who agreed or strongly agreed was similar (89%), and the proportion of participants who strongly agreed did not change significantly from pre- to post-training.

In California, minors have a constitutional right to obtain an abortion confidentially. Prior to the training, less than half of participants (49%) disagreed or strongly disagreed with the statement "Healthcare providers should not conduct an abortion procedure on a minor without guardian knowledge or consent," while 26% were neutral. The majority (88%) disagreed or strongly disagreed after training. The proportion of participants who strongly disagreed increased

significantly from pre- (28%) to post-training (57%), p <0.001, indicating the proportion of providers who understood that neither guardian notice nor consent is necessary to conduct an abortion was significantly higher after training than before the training.

TABLE 3. PARTICIPANTS' ATTITUDES ABOUT SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR FOSTER YOUTH BEFORE AND AFTER TRAINING.

	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)
By screening for adverse childhood experiences, I can be better informed about the different health risk behaviors foster youth may be engaged in (n = 58)					
Pre-training	37 (64%)	21 (36%)	0	0	0
Post-training	49 (84%)*	8 (14%)	1 (2%)	0	0
Informing youth in the foster system about contraceptive options is only marginally helpful in reducing pregnancies because most foster youth want to become pregnant (n = 58)					
Pre-training	0	5 (9%)	7 (12%)	26 (45%)	20 (34%)
Post-training	5 (9%)	3 (5%)	1 (2%)	15 (26%)	34 (59%)**
By fostering a positive relationship with my patient in foster care, I can increase the likelihood that they will feel comfortable talking about sensitive information with me (n = 57)					
Pre-training	44 (77%)	13 (23%)	0	0	0
Post-training	49 (86%)	8 (14%)	0	0	0
Although various historical practices may make youth in foster care suspicious of using long-acting reversible contraceptives, it is important that providers ensure youth choose the most efficacious contraceptive that is safe for the youth to use (n = 57)					
Pre-training	32 (56%)	18 (32%)	5 (9%)	0	2 (4%)
Post-training	40 (70%)	11 (19%)	4 (7%)	1 (2%)	1 (2%)
Healthcare providers should not conduct an abortion procedure on a minor without guardian knowledge or consent (n = 58)					
Pre-training	1 (2%)	8 (14%)	15 (26%)	18 (21%)	16 (28%)
Post-training	4 (7%)	0	3 (5%)	18 (31%)	33 (57%)***

*p-value for pre-training to post-training change is 0.007

**p-value for pre-training to post-training change is 0.002

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

Self-efficacy

Mean self-efficacy scores increased significantly from pre- to post-training for five of six items (see Table 4). The largest improvement (+0.72) was seen for the item "I can effectively discuss sexual exploitation and abuse with a youth I am caring for."

TABLE 4. MEAN SELF-EFFICACY SCORES BEFORE AND AFTER TRAINING.

Item		Pre-training		Post-training			
	n	Mean	SD	Mean	SD	Difference	*p*
I can effectively discuss sexual exploitation and abuse with a youth I am caring for	58	3.60	1.01	4.32	0.81	+0.72	<0.001
I am comfortable providing sexual health services for a 12-year-old without parent/guardian knowledge or consent	59	3.91	1.00	4.52	0.75	+0.61	<0.001
If I suspect child abuse of a foster youth in my care, I am confident in knowing who to report it to	58	4.25	0.92	4.78	0.42	+0.53	<0.001
I am comfortable discussing community suspicions and cultural myths about the negative impacts of long-acting contraceptives with youth	59	3.64	1.03	4.15	0.86	+0.51	<0.001
I am confident explaining to a guardian, social worker, or lawyer that I will not share youth's sexual and reproductive health information without proper authorization	59	4.35	0.88	4.80	0.41	+0.45	<0.001
I know how to determine whether a patient is in the foster system	57	3.91	0.96	4.10	1.07	+0.19	0.170

Limitations of the Evaluation

This evaluation was limited by its small sample size as well as its low survey response rate. Additionally, due to time constraints among participants, trainers were unable to collect information on participant demographics, such as age, gender identity, type of provider, or years in practice. Future evaluations would benefit from assessing relationships between demographic characteristics and training outcomes. Finally, this evaluation only assessed outcomes immediately after training. Further study is needed to determine whether improvements in

knowledge, attitudes, and self-efficacy persist over time and whether these findings are associated with improved outcomes for foster youth. The most rigorous way to evaluate this training would be to compare outcomes among healthcare providers who take the training with outcomes in a control group of providers who have not yet taken the training.

Discussion and Conclusions

Providers' pre-training knowledge of the unique sexual and reproductive health-related needs of youth in foster care was low, particularly in the areas of providing foster-friendly care and legal requirements for consent, confidentiality, and reporting. The training significantly improved providers' overall knowledge about sexual and reproductive healthcare for foster youth immediately post-training. Both before and after training, participants demonstrated significant knowledge gaps related to taking an appropriate sexual and reproductive health history and the types of health information that may be shared with guardian(s), suggesting a need for further training in these areas.

Training also significantly changed providers' attitudes around the importance of screening foster youth for adverse childhood experiences, the effectiveness of discussing contraception in reducing pregnancy among foster youth, and the appropriateness of performing an abortion for a minor without guardian consent or knowledge.

Both before and after training, a large majority of participants agreed that providers should ensure youth choose the most effective contraceptive option, irrespective of the youth's preferences. This finding likely reflects providers' familiarity with recommendations (e.g., from the American Academy of Pediatrics) to treat long-acting reversible contraceptives (LARC) as "first-line" for adolescents and to provide tiered contraceptive counseling in which LARC are discussed first. This finding may also suggest providers have implicit or explicit biases about the behaviors, risks, and needs of youth in foster care. This indicates a need for training about both historical and ongoing reproductive coercion in the United States; it also suggests a need for further training around the importance of a shared decision-making contraceptive counseling model, which focuses on the patient's priorities and preferences and directs the provider to support youth in choosing the contraceptive methods youth feel are best for them. Interestingly, although participants indicated they believe they should ensure youth choose LARC regardless of historical practices that may make youth in foster care suspicious of these devices, their reported self-

efficacy in discussing community suspicions and cultural myths about the negative impacts of LARC with youth was high at baseline and significantly increased from pre- to post-training.

Participants' self-efficacy significantly increased after the training in all but one area. No improvement was seen in participants' self-efficacy in determining whether a patient is in the foster system, and participants scored lowest in this area post-training. This finding suggests a need for further training on this topic. Of note is that there was a discordance between participants' self-efficacy and knowledge prior to training, as providers were more confident than they were knowledgeable. For example, prior to training, reported self-efficacy was highest (4.35 on a 5-point scale) for the item "I am confident explaining to a guardian, social worker, or lawyer that I will not share youth's sexual and reproductive health information without proper authorization;" however, prior to training, only 30% of participants correctly answered a question indicating they knew a signed medical release authorization is required to share sexual and reproductive health information with a youth's attorney and/or social worker. Similarly, providers' reported high pre-training self-efficacy (4.25 on a 5-point scale) in knowing where to report suspected abuse; however, prior to training, only 17% of participants correctly answered a knowledge question about who to notify if a foster youth reports rape or sexual assault. Therefore, among healthcare providers who frequently work with youth in foster care, confidence regarding sexual and reproductive healthcare for foster youth may not accurately reflect knowledge in this area. Ongoing training, particularly regarding consent, confidentiality, and reporting laws, may therefore be important even for experienced providers.

Overall, this evaluation suggests a need for sexual and reproductive health training for healthcare providers who care for foster youth, including those with experience working with the foster population. The evaluation also suggests such training may significantly improve providers' knowledge, attitudes, and self-efficacy. 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, self-efficacy, and behavior, as well as expansion of the training to include providers with less experience in caring for foster youth. This continued evaluation would ideally be done in comparison to control group who has not yet taken the training.