SEXUAL HEALTH CONVERSATIONS:

Evaluating a sexual health communication training for DCFS social workers and other DCFS personnel

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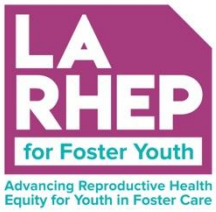

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Purpose

The *Sexual Health Conversations* training was developed by Los Angeles County Department of Children and Family Services (DCFS) in partnership with the Harvey Institute to address the high rate of unplanned pregnancies among youth in foster care. The training, consistent with DCFS' Youth Reproductive Health and Pregnancy policy (0600-507.10), aims to increase participants' awareness and understanding of the rights of youth in foster care, particularly regarding their right to access medically-accurate sexual and reproductive health information and care. This evaluation report analyzes participants' knowledge, attitudes, perceived barriers and helpfulness, communication behavior, and satisfaction prior to, immediately after, and three months after the training.

Methods

Training

Participants who attend the *Sexual Health Conversations* training have the opportunity to assess and expand their comfort level and willingness to address youth and caregiver sexual health-related concerns or issues in their professional role within DCFS. During the training, participants review DCFS policy, learn practical sexual health communication tools such as suspending judgments, basic principles of sexual health (as defined by the World Health Organization[a]) and sexual health terms. They also practice skills to effectively engage in conversations about sexual health with youth under DCFS supervision and care. The three-hour training was delivered to DCFS line staff Children's Social Workers, Supervising Children's Social Workers, Public Health Nurses, Public Health Nurse Supervisors, and DCFS-contracted life coaches several times per year.

[a]*World Health Organization (2006). Defining sexual health: Report of a technical consultation on sexual health. 28–31 January 2002, Geneva*

Sample

All persons who attended a training between November 2017 and August 2018 (6 trainings total) were invited to participate in pretest and posttest surveys for this report. A total of 224 completed at least pretest or posttest, and 208 completed both pretest and posttest. Attendees were also invited to take a third survey, 3 months later, to assess the longer-term impacts of the training and 64 did so (31%). DCFS leadership designated the *Sexual Health Conversations* training as mandatory for DCFS line staff. At the time of data collection, approximately one third of DCFS line staff had completed the training. Each training session accommodated a maximum of 40 attendees.

Data collection and instrument

In partnership with the Los Angeles Reproductive Health Equity Project for Foster Youth (LA RHEP), DCFS, the University Consortium for Children and Families/University of California – Los Angeles (UCLA), and the Harvey Institute, Seattle Children's Research Institute revised an existing pretest/posttest survey for the purposes of this evaluation. The revised pretest, posttest, and 3-month electronic surveys were designed to measure the impact of the training on psychological factors related to behavior change (i.e., participant knowledge, attitudes, perceived barriers, perceived helpfulness, and intentions) related to communicating effectively with foster youth about sexual health as well as communication behaviors and satisfaction with the training. To maximize participation, surveys were designed to be brief (i.e. to take less than 10 minutes to complete). The University Consortium/UCLA administered all electronic surveys. The pretest and posttest surveys were completed in person; links to 3-month surveys were delivered via email. Participants who completed the 3-month survey were placed in a lottery to win a $100 gift card.

Pretest and posttest surveys included six multiple-choice and one true/false question designed to assess participants' **knowledge** of the training material. All surveys (pre, post, 3-month) included two five-level Likert items assessing participants' **attitudes** about providing sexual and reproductive health care for youth in foster care as well as ten true/false questions reflecting **perceived barriers** to talking about sex with youth on their caseloads. Posttest and 3-month surveys each had two questions on **perceived helpfulness** of training. The posttest survey also had a single question on **intention** to engage in more sexual health conversations. For those who had adolescents on their caseloads at the time, the baseline and 3-month surveys included

questions about sexual health communication **behaviors**. All procedures and materials were approved by the California State Committee for the Protection of Human Subjects.

Analysis

Participants' demographic characteristics (gender, race, age, education, job title, language) collected on the pretest survey were summarized as frequencies and percentages. Responses to knowledge, attitudes, perceived barriers, intentions, and behavior questions were summarized as frequencies and percentages for each timepoint collected (pretest, posttest, and at 3 months). The statistical significance of changes in these outcomes over time was assessed using Pearson's chi-squared tests. For the total percentage of knowledge questions answered correctly, mean and standard deviation were presented, and a two-sample t-test was used to assess statistical significance of changes over time. Helpfulness of training was also summarized in terms of frequency of response, immediately post-training and 3 months later.

Results

Participants

We analyzed data for the 208 persons who completed both pretest and posttest as well as for the 64 who completed both pretest and 3-month surveys. Overall, the majority participants were female (86%). Most identified as Hispanic/Latinx, followed by African American/Black, White/Caucasian, and Asian Pacific Islander (Table 1, next page). Over two-thirds of the sample spoke English as a second language (most common primary language was Spanish). Participants ranged in age from 24 to 69 years old, with most between 30-49 years of age. Over half of the sample had a master's degree in social work or in another field (57%). Another 41% had a bachelor's degree in social work or another field.

In the sections that follow, we present results comparing pretest to posttest and pretest to 3-month results. As noted, not all outcomes were assessed at all time points. Because the number included in the 3-month follow up differs significantly from the number who participated in the pre- and posttests (i.e., only 31% of the group completed the 3-month survey), in the cases where an outcome was collected at all 3 time points (e.g., for attitudes) we present pretest to posttest data and pretest to 3-month data in separate tables.

TABLE 1. DEMOGRAPHICS (N = 200[a,b])

What is your gender?	
Female	86%
Male	14%

What is your title?	
CSW	81%
SCSW	16%
CSA	1%
RA	1%
Other	1%

What is the highest level of your formal education?	
BA/BS degree	31%
BSW degree	11%
MA/MS degree	17%
MSW	40%
PsyD	1%
PhD	1%

Age (years)	
18-29	17%
30-39	35%
40-49	31%
50-59	10%
60-69	7%

How do you identify yourself in terms of ethnicity/race?	
Hispanic/Latino	41%
African American/Black	24%
White/Caucasian	15%
Asian/Pacific Islander	14%
Other	6%

Is English your second language?	
Yes	74%
No	26%

If yes, what is your first language?	
Spanish	75%
Korean	8%
Japanese	4%
Armenian	6%
Cantonese	2%
Chinese	2%
Vietnamese	2%

[a]Not every participant provided a response for each demographic question. We calculated percent by taking the number in each category and dividing it by the total number who responded to that question. For example, 199 participants provided their gender, and 171 responded that they were female. Thus, percent for this response is 171/199 = 86%.

[b]Percents do not always add up to 100 due to rounding.

Knowledge

Participants demonstrated a significant improvement in overall sexual health **knowledge** at the end of the training. On average, participants answered 54% of the seven questions correctly prior to the training, and 79% immediately after the training (on the posttest). The largest changes were seen in questions on the organization that created the definition of sexual health, the six principles of sexual health, and key sexual health conversation skills.

TABLE 2. KNOWLEDGE (N=208).[a]

	Pretest	Posttest	Statistical significance
The current working definition of sexual health was developed in 2006 by the: *(Answer: WHO)*	62%	92%	***
Which of the following is NOT one of the six principles of sexual health: *(Answer: Confidentiality)*	17%	85%	***
Which of the following is a term that is a sexual health conversation skill: *(Answer: Suspending judgments)*	20%	76%	***
A sexual health conversation: *(Answer: Can happen anywhere between anyone)*	90%	96%	*
Which statute provides CSWs with authority to discuss sexual/reproductive health with Foster Youth? *(Answer: Welfare and Institutions Code 369)*	34%	43%	
What options must a CSW explore with a FY who discloses she is pregnant? *(Answer: All of the above)*	92%	97%	*
True or False: A pregnant youth may not stay in a placement if caretakers aren't informed and supportive of the pregnancy. *(Answer: True)*	64%	65%	
Overall percentage of knowledge questions answered correctly (Mean, Standard Deviation)	**54% (SD=18.8)**	**79% (SD=15.4)**	***

Statistical significance: * p<0.05, *** p<0.001. SD: Standard Deviation.

[a]Not every participant provided a response for each question (a total of 208 provided responses on both pretest and posttest). We calculated percent for each question by taking the number answering correctly and dividing it by the total number who responded to that question.

Attitudes

We also found that **attitudes** improved significantly immediately after the training. For example, prior to the training about half (52%) of participants reported agreeing or strongly agreeing that if they talk with youth about reproductive and sexual health the youth would be less likely to get pregnant (Table 3A). This number rose to 75% on the posttest (Table 3A). Comparison of pretest and 3-month surveys revealed a similar but non-significant increase in the proportion

who agreed or strongly agreed from 55% at baseline (on the pretest) to 79% at 3 months (Table 3B). Attitudes about feeling like a responsible social worker if they talked with youth on their caseloads about sex also increased in the expected direction, from 79% agreeing or strongly agreeing at baseline to 93% at posttest. When pretest and 3-month values were compared for this question, the number who agreed or strongly agreed were again similar but the trend was again non-significant, with 83% reporting agreeing/strongly agreeing on the pretest and 92% agreeing/strongly agreeing on the 3-month survey.

TABLE 3A. ATTITUDES (PRETEST VS. POSTTEST; N=207).[a,b]

	Pre	Post	Statistical significance
If I talk with adolescent youth on my caseload about reproductive and sexual health, they'll be less likely to get pregnant.			***
Strongly Agree	9%	25%	
Agree	43%	50%	
Neither Agree nor Disagree	35%	19%	
Disagree	8%	5%	
Strongly Disagree	6%	1%	
If I talk with adolescent youth on my caseload about reproductive and sexual health, I'll feel like a responsible social worker.			***
Strongly Agree	27%	39%	
Agree	52%	54%	
Neither Agree nor Disagree	17%	5%	
Disagree	3%	1%	
Strongly Disagree	2%	0%	

Statistical significance: *** p<0.001

[a]Not every participant provided a response for each question (a total of 201 provided responses on both pretest and posttest). We calculated percent by taking the number in each category and dividing it by the total number who responded to that question.

[b]Percents do not always add up to 100 due to rounding.

TABLE 3B. ATTITUDES (PRETEST VS. 3-MONTH; N=64).

	Pretest	3-Month	Statistical significance
If I talk with adolescent youth on my caseload about reproductive and sexual health, they'll be less likely to get pregnant.			Not significant
Strongly Agree	11%	21%	
Agree	44%	58%	
Neither Agree nor Disagree	38%	17%	
Disagree	3%	0%	
Strongly Disagree	5%	4%	
If I talk with adolescent youth on my caseload about reproductive and sexual health, I'll feel like a responsible social worker.			Not significant
Strongly Agree	28%	42%	
Agree	55%	50%	
Neither Agree nor Disagree	14%	8%	
Disagree	0%	0%	
Strongly Disagree	3%	0%	

Statistical significance: Neither outcome was statistically significant

Perceived Barriers

Overall, participants who attended the training reported low rates of **perceived barriers** to talking about sex with youth on their caseload at baseline (prior to the training). The most commonly perceived barrier was that talking about sex was difficult if they didn't know the teen very well; this barrier did not change significantly with the training. On the other hand, some **perceived barriers** to talking about sex did significantly decrease (Tables 4A, 4B, respectively). For example, on the pretest 16% of participants reported confusion about whether or not they were supposed to be talking about sex with youth on their caseloads. On the posttest only 4% reported this barrier. When we compared pre and 3-month values for participants who took both of these surveys, we found a similar and also significant trend: 22% of this group reported confusion about talking about sex with youth as a barrier on the pretest, and this decreased to 8% on the posttest.

Similarly, on the pretest 21% reported not having up-to-date sexual health information as a barrier and this number decreased significantly to 6% on the posttest. Among the smaller subset

who participated in the 3-month follow-up, we found a similarly significant but larger change pretest to 3 months in this outcome (23% reported this barrier on the pretest and 5% reported it on the 3-month survey). Participants were also significantly less likely to report fear of an allegation as a barrier to talking about sex with youth on their caseload from pretest (13%) to posttest (7%); this outcome was not significant when pretest and 3-month time points were compared but the trend was in the same direction (17% on pretest vs. 13% on posttest).

TABLE 4A. PERCEIVED BARRIERS (PRETEST VS. POSTTEST; N=208).

	Pre	Post	Statistical significance
It is difficult when I don't know the teen very well.	50%	41%	
I am not sure I am supposed to be talking with youth on my caseload about sex.	16%	4%	***
It conflicts with my morals, values, or religious beliefs.	5%	4%	
There is a generation gap and I can't relate to what the youth says.	4%	6%	
It is difficult when the teen is a different gender than me.	16%	12%	
It is difficult when the teen has a different sexual orientation than me.	7%	4%	
I don't want to encourage teens to have sex.	10%	8%	
I don't think I have up-to-date sexual health information.	21%	6%	***
I am afraid of an allegation.	13%	7%	*
I don't think it will help.	3%	1%	

Statistical significance: * is $p<0.05$, *** is $p<0.001$

TABLE 4B. PERCEIVED BARRIERS (PRETEST VS. 3-MONTH; N=64).

	Pretest	3-Month	Statistical significance
It is difficult when I don't know the teen very well.	59%	59%	
I am not sure I am supposed to be talking with youth on my caseload about sex.	22%	8%	*
It conflicts with my morals, values, or religious beliefs.	6%	5%	
There is a generation gap and I can't relate to what the youth says.	6%	8%	
It is difficult when the teen is a different gender than me.	22%	28%	
It is difficult when the teen has a different sexual orientation than me.	3%	8%	
I don't want encourage teens to have sex.	6%	3%	
I don't think I have up-to-date sexual health information.	23%	5%	**
I am afraid of an allegation.	17%	13%	
I don't think it will help.	0%	3%	

Statistical significance: * is p<0.05, ** is p<0.01

Perceived Helpfulness and Intentions

Participants reported high **perceived helpfulness** of the training immediately afterward, with 72% reporting that their knowledge had increased "a great deal" as a result of the training and 73% reporting that it had improved their ability to have conversations with youth around sexual and reproductive health (Table 4). Interestingly, perceived helpfulness was lower at 3 months, with some participants responding "somewhat" who had originally responded "a great deal." This trend was similar when analyses were restricted to only participants responding to both surveys, suggesting that some participants actually perceived the training to be less helpful at the 3-month time point than they did immediately afterwards. In terms of **intentions**, on the posttest most (84%) of participants reported that they agreed or strongly agreed that they intended to have more conversations about sex with youth on their caseloads. This question was not asked on the 3-month survey.

TABLE 5. PERCEIVED HELPFULNESS AND INTENTIONS (POSTTEST VS 3-MONTH).

	Posttest	3-Month	Statistical Significance
Did your knowledge about sexual health and reproduction for foster youth improve as result of this training? (Perceived Helpfulness) (N=206 on Posttest; N=59 on 3-Month)			**
A Great Deal	72%	58%	
Somewhat	28%	37%	
Not at all	0%	5%	
Did the training improve your ability to have conversations with youth about sexual health and reproduction? (Perceived Helpfulness) (N=205 on Posttest; N=58 on 3-Month)			***
A Great Deal	73%	53%	
Somewhat	27%	36%	
Not at all	0.5%	10%	
Posttest Only: As result of this training, I intend to have more conversations w/ youth on my caseload (Intentions) (N=203)			n/a
Agree / Strongly Agree	84%		
Neither Agree nor Disagree	15%		
Disagree / Strongly Disagree	1%		

Statistical significance: ** is p<0.01, *** is p<0.001

n/a: statistical significance of change not applicable because only asked question at a single timepoint

Behavior

At baseline, 102 (49%) reported that they had 1 or more adolescents on their caseloads. At the 3-month time point, a slightly greater proportion of participants (N=38; 59%) had at least one adolescent or young adult on their caseload. A total of 31 had adolescents on their caseloads at both time points (15%). When these persons were compared over time, 52% had had a conversation about a sexual health topic on the pretest. This number increased to 70% on the 3-month survey (non-significant change). At the 3-month time point, 50% of participants with adolescents on their caseloads also reported that they thought they had had *more* conversations with youth about sexual health than they would have prior to the training (Table 6).

TABLE 6. BEHAVIOR CHANGE AMONG PARTICIPANTS WITH ADOLESCENTS ON THEIR CASELOADS (PRETEST VS 3-MONTH).

	Pretest	3-Month	Statistical Significance
During the past 4 weeks, how many times have you had conversations with the youth on your caseload about [sexual and reproductive health topics]? (N=31 that had adolescents on caseload at both time points and responded to question)			Not significant
At least once	52%	70%	
Never	48%	30%	
Have you had more conversations with youth than you would have, about either reproductive/sexual health, relationships, or access to reproductive health services, after taking the training? (N=36 that had adolescents on caseload at 3-month time point and responded to question)			n/a
Yes		50%	
No		50%	

n/a: statistical significance of change not applicable because only asked question at a single timepoint

Satisfaction

Participants reported high satisfaction with the training with the vast majority agreeing or strongly agreeing with all 9 statements (Table 7).

TABLE 7. SATISFACTION (POSTTEST ONLY; N=201).[a]

The training was coherent and well organized.	
Strongly Agree	60%
Agree	24%
Disagree	1%
Strongly Disagree	15%
The training helped me to be better prepared to do my job.	
Strongly Agree	50%
Agree	33%
Disagree	3%
Strongly Disagree	14%

The training was presented at the appropriate level for my knowledge and ability.	
Strongly Agree	55%
Agree	29%
Disagree	1%
Strongly Disagree	15%
The trainer displayed mastery of the relevant issues and topics discussed.	
Strongly Agree	60%
Agree	24%
Disagree	1%
Strongly Disagree	15%
The trainer was responsive to trainees, by answering questions and responding to concerns.	
Strongly Agree	61%
Agree	23%
Disagree	1%
Strongly Disagree	15%
The trainer helped trainees relate training content to practice.	
Strongly Agree	59%
Agree	24%
Disagree	1%
Strongly Disagree	15%
The trainer's teaching strategies were effective for me.	
Strongly Agree	60%
Agree	24%
Disagree	1%
Strongly Disagree	14%
Participating in this training increased my understanding of the topic.	
Strongly Agree	59%
Agree	25%
Disagree	2%
Strongly Disagree	14%

I will apply knowledge or skills I have learned from this training in my job.	
Strongly Agree	54%
Agree	30%
Disagree	2%
Strongly Disagree	14%

[a]Not every participant provided a response for each question (a total of 201 provided responses on the posttest to at least one of the above questions). We calculated percent by taking the number in each category and dividing it by the total number who responded to that question.

Limitations of the Evaluation

Main limitations of this evaluation include its lack of a control group, and the low response rate at the 3-month time point which is likely due to participants having high competing time demands and our inability to monetarily incentivize completion of the electronic survey (due to DCFS regulations). Without a comparison group, firm conclusions cannot be drawn about the effectiveness of this training. However, the fact that changes were in the expected directions and consistent across domains (significantly improved knowledge, attitudes, and perceived helpfulness of training and reduced barriers) and time points provides some evidence that changes seen in this study were due to the effects of the training. It is also difficult to assess whether effects of the training are sustained over the long-term, particularly given the low 3-month response rate. Additionally, the fact that the training is not, as of yet, universally attended by DCFS Social Workers and other personnel who interact with adolescent foster youth means results may not be generalizable to all the entire population of DCFS personnel eligible for the training. Said more explicitly, because participation was at least to some extent voluntary, attendees are likely to have more positive beliefs about discussing sexual health than those who did not attend, since they chose to attend this 3-hour training on the subject. If/when the training is more universally implemented, some attendees may have less certain attitudes around talking about sex, or higher perceived barriers. Changes in scores in the above areas could become larger (if pretest scores started lower and changed more), or smaller (if participants began with and rigidly adhere to negative beliefs about talking about sex with youth). Therefore, an ongoing evaluation that includes a comparison group, a longer follow-up time-period, and resources/strategies to increase participation throughout the follow-up assessment period would allow for a more robust evaluation of this training.

Discussion and Conclusions

Participants who attended the *Sexual Health Conversations* training and participated in this study demonstrated improved knowledge, attitudes about talking about sex with youth on their caseloads, reduced barriers to talking about sex (particularly being certain it was appropriate for them to talk about sex and feeling like they had up-to-date sexual health knowledge). They were also more likely to perceive conversations about sex as helpful. Behavioral outcomes suggest that at least some participants are increasing communications about sex with youth on their caseloads, although the trend was non-significant (very likely due to the very small N – that is the very small number of participants with adolescents on their caseloads). Participants were highly satisfied with the training. Collectively, findings suggest that this training reaches its intended goals and is highly acceptable, at least amongst the group that attended during the evaluation time period. 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, perceived barriers and helpfulness, communication behavior. Although we recognize that this may not be possible, this continued evaluation would ideally be done in comparison to control group with similar demographic characteristics of participants who have not yet taken the training.