Interview Survey of Adolescents in Foster Care in Los Angeles County Regarding Sexual and Reproductive Health Communication and Access to Resources:

Findings From 2021

RHEP for Foster Youth

Advancing Reproductive Health Equity for Youth in Foster Care

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Abstract

In 2019 and 2021, the Reproductive Health Equity Project for Foster Youth surveyed Los Angeles County youth in foster care both to fill a gap in the research literature on how youth in foster care receive sexual and reproductive health (SRH) information and services and to estimate child welfare workers' roles in providing SRH information and services. The study, which is expected to include at least one other wave of data collection, sheds light on implementation of California's Foster Youth Sexual Health Education Act, passed in 2017. The act mandates that child welfare workers receive training in providing age- and developmentally appropriate SRH information to youth and requires that they provide such information and access to services for youth in foster care age 10 and older annually.

Youth responses indicated that nearly half (45%) of youth in foster care in 2019 did have conversations with their social workers about SRH topics, and by 2021, the percentage had increased to 56%. Although differences between the two surveys' findings reflect not only change over time but also differences in data collection methods due to the COVID-19 pandemic and the effects of the pandemic itself, it does appear that despite the pandemic's disruptions, more youth received needed information in 2021 than did in 2019. Nevertheless, a significant proportion of youth report that they are not having the required conversations with their social workers.

In both surveys, younger youth were less likely than older youth to report that they had spoken with their social workers about SRH, and some differences were also observed among youth of different racial and ethnic backgrounds. These differences raise questions for future research regarding social worker training, youth recall, and cultural differences among youth that require consideration in planning and implementing services to achieve equitable outcomes.

I. Introduction

When youth enter foster care in California, the child welfare agency in the county where they live takes legal responsibility for them, including the responsibility to support their healthy development and meet their education and health care needs (California Welfare and Institutions Code, § 16000.1 (2003); California Welfare and Institutions Code, § 16001.9(a) (2019); California Department of Social Services, 2016; Social Security Act, 2011). Caregivers, including relative and nonrelative caregivers and such residential placements as group homes, also have responsibility to support youth's healthy development and meet their education and health needs (California Department of Social Services, 2016, 2021).

The sexual and reproductive health (SRH) outcomes of youth in foster care, however, clearly indicate that the child welfare system is not meeting youth needs for SRH information and services while they are in foster care. This report summarizes contemporary research on SRH outcomes among youth in foster care and describes recent California legislation designed to provide guidance and assign responsibility for providing youth in foster care with age-appropriate and developmentally appropriate information and services related to SRH. The report then presents the results of two surveys designed to assess whether the percentage of Los Angeles County youth in foster care who receive the care and support mandated by the legislation is growing.

Sexual and Reproductive Health Outcomes for Youth in Foster Care

Youth in foster care face disproportionately poor health outcomes in several areas, including such poor SRH outcomes as sexually transmitted diseases or infections (STDs/STIs), early pregnancy, and poor pregnancy outcomes. In a study conducted in California, 21-year-olds who had been in foster care reported having had an STI at almost twice the rate observed in the general population of adolescents (Courtney, et al., 2018). Other studies have reported similar results. For example, Ahrens, et al. (2010) reported that youth who had spent time in foster care had rates of certain STIs at two to ten times the rate observed in the general population. At ages 17, 19, and 21, female foster youth in California reported experiencing pregnancy at two to three times the rate of pregnancy among youth in the general population (Courtney, Charles, Okpych, Napolitano, and Halsted, 2014; Courtney, et al., 2017; Courtney, et al., 2018). Among 17-year-old females in foster care in California, 26% reported at least one pregnancy, compared with 10% of youth in the general population (Courtney, et al., 2014). By age 21, about 60% of women who had been in foster care in California reported at least one pregnancy (Courtney, et al., 2018). Among youth who had been in foster care in Los Angeles County, 58% of females reported experiencing a pregnancy by age 19, and 20% of males reported impregnating a partner by age 19 (Courtney, et al., 2014).

In prior studies, adults asked about these pregnancies assumed that the majority were intentional, designed to meet an unmet need for love, fill a "void," or "fulfill a need to have a family" (Bruce, 2016; Constantine, Jerman, and Constantine, 2009). Research conducted by Courtney, et al.

(2017), however, contradicts this assumption. When researchers asked 19-year-old youth in Los Angeles who had been pregnant about the intentionality of their last pregnancy, only 33% said they "definitely" or "probably wanted" to get pregnant at the time (Courtney, et al., 2017). Of 19-year-old men in care who reported impregnating a partner, under 30% said they "definitely" or "probably wanted" their partner to become pregnant (Courtney, et al., 2017).

Youth in foster care also have poor prenatal outcomes. At age 17, over 42% of youth in care who reported having been pregnant said they suffered stillbirth or miscarriage, and over 20% never received prenatal care (Courtney, et al., 2014). Youth in care reported limited use of other SRH care and services as well. Of the 19-year-old females who had been pregnant, only 28% were using contraception at the time of conception (Courtney, et al., 2017).

Social Determinants of Health Equity

Disproportionately poor health outcomes and limited access to or use of health care services often result from the intersection of barriers at different levels (e.g., individual, relationship, community, and society levels) that compound and impede individuals' agency and ownership of their own health. In the case of poor SRH outcomes for youth in foster care, one contributor may be limited access to sexual health information and education (Constantine, et al., 2009; Ross, Kools, and Laughon, 2020). Teens in care typically undergo many placement changes during adolescence, with almost half of youth reporting four or more placements by age 17 (Constantine, et al., 2009; Courtney, et al., 2014). Frequent moves can limit access to accurate sexual health information from sources that are available to non-foster youth, for example, school-based sexual health education classes (Ahrens, Spencer, Bonnar, Coatney, and Hall, 2016). Frequent moves also make it less likely that a young person will develop a trusting relationship with a consistent caregiver or health care provider (Albertson, et al., 2018; Harmon-Darrow, Burruss, and Finigan-Carr, 2020; Ross, et al., 2020).

A lack of explicit support from the adults responsible for youth in foster care may also contribute to youth's poor SRH outcomes. In a national poll, 52% of teens ages 12–15 said their parents most influence their decisions about sex (Power to Decide, 2016). Youth in foster care may have limited or no contact with biological family, however, leaving gaps that others—for example, health care providers, foster caregivers, and social workers—must fill (Albertson, et al., 2018; Ross, et al., 2020). If those adults feel uncomfortable, unprepared, or unauthorized to play this role, youth may not receive this crucial information (Albertson, et al., 2018; Harmon-Darrow, et al., 2020). Although lack of accurate information on SRH is a likely contributor to poor SRH outcomes among youth who are or have been in foster care, no studies have quantitatively assessed youth sources of SRH information.

California social workers have described a number of barriers to their providing information and access to services for youth in care. Bruce (2016) conducted interviews with representatives from

18 California counties in 2015. These child welfare professionals identified multiple barriers to engaging in meaningful conversations with young people about reproductive health: lack of training, not prioritizing such conversations, lack of comfort, conflicting beliefs about the role of the social worker, conflicting personal values and beliefs, and the fact that no one is tracking the sexual health outcomes of youth in foster care and whether such conversations occur (Bruce, 2016). Unlike such aspects of child and youth care as access to food and shelter, safety and health standards, and so on, until recently neither the state nor county welfare agencies provided foster caregivers and social workers with clear mandates or guidance for supporting the SRH care and development needs of youth in care. In 2015, Bruce (2016) reviewed child welfare policies in 26 California counties and found that only two counties had "publicly-accessible, stand-alone policies that explicitly detailed departmental guidelines and procedures for supporting youths' sexual and reproductive health needs."

A 2009 survey of child welfare workers in three California counties also looked at social worker communications with foster youth about SRH and revealed several barriers that prevented these workers from providing SRH information to the youth with whom they worked (Constantine, et al., 2009). For example, some were concerned that if they provided youth with information and access to care that their parents found objectionable, they could jeopardize relationships that are essential to family reunification. Some noted the absence of policies about providing SRH information or access to SRH care, and others noted policies that prohibited such conversation. These staff members noted that when no one has clear responsibility for addressing youth's SRH needs, those needs often go unaddressed.

Yet another contributor to poor SRH outcomes for youth in foster care may be perceived or actual barriers to accessing desired SRH care. Adolescents in general face several barriers to accessing SRH care, including confidentiality and stigma concerns and scheduling, financial, and transportation barriers (Decker, et al., 2021; Fuentes, Ingerick, Jones, and Lindberg, 2018; Johnson, Dodge, Hacker, and Ricciotti, 2015; Lim, Chhabra, Rosen, Racine, and Alderman, 2012; Miller, Wicklife, Jahnke, Linebarger, and Dowd, 2014). Some youth face additional barriers because of their identity or living situation. In one study, youth who identified as male reported believing SRH services are not for them (Marcell, et al., 2017). Youth may face limitations placed on them by their caregivers such as house rules requiring abstinence or prohibiting contraception. They also may be in placements in which it is not safe to acknowledge their sexual orientation or gender identity, making it more difficult to ask for and access appropriate SRH services.

Another important potential contributor to poor SRH outcomes among youth in foster care may be implicit and explicit bias in the health care system. Youth in foster care are more likely than other youth to identify as members of marginalized communities that often face barriers to health care. For example, youth in foster care are twice as likely as other youth to identify as LGBTQ+[1]

[1] Lesbian, gay, bisexual, transgender, queer, or other sexual orientations.

(Baams, Wilson, and Russell, 2019; Courtney, et al., 2017) and over 90% of youth in foster care in Los Angeles are youth of color (KidsData, 2018). Youth who identify as LGBTQ+ have reported delaying care for fear of discrimination (Macapagal, Bhatia, and Greene, 2016). Youth of color also have reported concerns about discrimination when accessing SRH services (Galloway, Dufy, Dixon, and Fuller, 2017). Beyond perceptions, well-documented racial bias in health care has led to differences in treatment and health outcomes (Trent, et al., 2019). In addition, biases regarding the culture of youth's families and the values of the youth themselves may lead child welfare workers to worry more or less about offending youth or their families or to make assumptions about their values regarding sexual health or early parenting, influencing the SRH support child welfare workers provide.

Recent Related Legislation

Since 2015, the California Legislature has passed two laws mandating that health, including sexual health, education be available to California youth. The California Healthy Youth Act (2015) requires that all public and charter schools provide their students with health instruction that adheres to state standards at least twice, once in the middle grades and once in high school. Two years later, the Legislature passed the California Foster Youth Sexual Health Education Act (CFYSHEA; 2017), guaranteeing the rights to SRH education and services for youth in foster care. CFYSHEA requires county child welfare agencies to ensure their social workers receive training in how to support healthy sexual development among youth in care. CFYSHEA also specifies responsibilities for social workers to support the healthy sexual development of youth, including the following:

- Each year social workers must inform all youth on their caseloads aged 10 years and older and non-minor dependents (youth ages 18–21) of their rights to access age-appropriate, medically accurate information about reproductive and sexual health care; to consent to SRH services; and to confidentiality regarding those services.

- Each year social workers must inform all youth on their caseloads aged 10 years old and older and non-minor dependents (youth ages 18–21) about how to access reproductive and sexual health care services and facilitate youth access to that care, including removing any barrier to care, if the youth requests such support.

- Social workers must ensure that youth in foster care receive comprehensive sexual health education at least once in middle school and at least once in high school. If youth in care do not receive that instruction in school, the worker must connect the youth to a community-based sexual health education program that meets state standards for sexual health education (California State Board of Education, 2008; California Department of Education, 2019).

Study Purpose

Given the poor SRH outcomes observed among California youth in foster care and the recent legislation concerning their access to SRH information and care, the Reproductive Health Equity Project for Foster Youth (RHEP) conducted this study to address several questions related to sources of SRH support and information available to California youth in foster care. An additional goal was to assess whether the SRH information and care experience of California youth in foster care changed after passage of CFYSHEA. In light of both CFYSHEA provisions and the existing gaps in research on the sources of SRH information and services that youth in foster care access, this study addresses three related but distinct topics:

1. whether youth in foster care reported having conversations about SRH with their social workers, as specified in CFYSHEA;

2. the primary sources of SRH information and education that youth in foster care draw upon in addition to child welfare; and

3. barriers to receiving SRH information and services that youth in foster care experience.

RHEP first surveyed youth in foster care on these topics in 2019, two years after CFYSHEA went into effect. This report focuses on results from RHEP's subsequent 2021 survey, which administered all the questions asked in 2019 but employed data collection methods somewhat different from those employed in 2019 in order to adhere to safety measures regarding physical distancing during the COVID-19 pandemic. After presenting the 2021 results, the report describes the differences between the two studies and their results. At least one additional survey is planned for 2023.

II. Methods

RHEP chose to conduct this study in Los Angeles County, home to one-third of the approximately 60,000 youth in foster care in California, for several reasons (KidsData, 2018). Los Angeles has the largest and most diverse child welfare population in both California and the United States, which allowed for a diverse sample of youth for this study. In addition, Los Angeles County's child welfare agency, the Department of Children and Family Services (DCFS), is a member of the RHEP collaborative and was supportive of the study. Finally, DCFS dedicated time and resources to implementing CFYSHEA when it first became law by updating policies and practices, implementing new required training and providing clear messaging to staff that implementation is a priority. Thus, it was reasonable to expect to see some change and growth in Los Angeles County's child welfare workers' implementation over time.

The Children's Law Center of California (CLC) serves all youth in foster care in Los Angeles County, in this case, by providing them with legal representation. Like DCFS, CLC is also a member of the RHEP collaborative. CLC obtained a juvenile court order authorizing it to conduct this research, and Advarra, Inc. provided Institutional Review Board (IRB) services for the study. The IRB determined that this research is exempt from IRB oversight and waived parental consent because the data were being collected for quality improvement purposes.

Sample Selection and Consent

In 2021, CLC generated a list of approximately 6,000 clients in its database who were between the ages of 12 and 20 and had been in foster care for at least one year. Interviewers emailed the CLC attorney representing each sampled youth to explain the study and see if the attorney objected to the youth's participation in the survey. If the youth's attorney did not object, the interviewer contacted the youth; explained the study and the youth's right not to participate; and requested the youth's consent to participate, offering a $5 gift certificate for participation. If the youth consented, the interviewer conducted the interview or set up a time to speak with the youth at a later date.

Instrument and Data Collection

In early 2021, CLC hired four young adults with experience in foster care and trained them in oral survey techniques, trauma-informed practice, and confidentiality and consent laws. These young adults conducted the survey. The survey instrument (Appendix A) covered the following topics:

- Demographics (age, primary language, race and ethnicity, gender identity, sexual orientation)
- SRH conversations with caseworkers in the past year (basic SRH information, information on access to care)
- Facilitation of access to SRH care by caseworkers

- Perceived barriers to accessing SRH care
- Impact of the COVID-19 pandemic on youth access to caseworkers, health care, and other important services

Interviewers spoke with 124 youth by telephone or video conference and recorded youth responses to each question using a CLC-provided tablet. The tablets automatically uploaded responses to the cloud.

Data Analysis

De-identified survey data were provided to Seattle Children's Research Institute researchers, who generated summary statistics (averages and percentages) and performed multivariate analyses where sample sizes permitted. The multivariate analyses estimate differences among groups defined by youth age, race and ethnicity, gender identity, and sexual orientation while holding the other characteristics constant. Researchers conducted statistical significance tests when appropriate and considered test statistics with p values less than or equal to 0.05 statistically significant.

III. Respondent Demographics

Most of the youth who participated in the survey were between 13 and 19 years old, with an average age of 16 (Table 1). Almost 90% of respondents spoke primarily English at home; 7% spoke both English and Spanish; and 3% spoke primarily Spanish. Three-fifths (60%) identified as Latina or Latino, 17% as African-American or Black, 8% as white, and 14% reported more than one racial or ethnic group. Just over half (53%) identified as female or transgender female (female gender identity); 43% as male or transgender male (male gender identity); and 3% as agender, gender nonbinary, gender queer, or another gender-diverse category. Most (82%) selected straight (heterosexual) as their sexual orientation, and 3% preferred not to identify a sexual orientation. The remaining 15% selected bisexual (11%), gay (1%), questioning or unsure (1%), or multiple categories (3%).

Table 1

Demographics of 2021 Survey Sample and Los Angeles Youth in Foster Care on July 1, 2021

Characteristic	Survey Sample		Los Angeles Youth in Foster Care, age 12–20	
	N	Percent	*N*	Percent
N	124	100.0	10,871	100.0
Age in years [mean(*SD*)][a]	16.2	2.5	15.9	—
12–13 years old	—	—	2,782	25.6
14–16 years old	—	—	4,125	37.9
17–20 years old	—	—	3,964	36.5
Race and ethnicity				
African-American or Black	20	17.4	2,684	24.7
Latina or Latino	69	60.0	6,371	58.6
White or Caucasian	9	7.8	1,170	10.8
Other	1	0.9	646	6.0
Multiple races reported	16	13.9	—	—
Gender identity				
Female	64	53.3	—	—
Male	52	43.3	—	—
Nonbinary, gender fluid, gender nonconforming, or gender queer	3	2.5	—	—
Multiple (more than one category)	1	0.8	—	—
Sexual orientation				
Bisexual	13	10.7	—	—
Gay	1	0.8	—	—
Straight (heterosexual)	100	82.0	—	—
Questioning or unsure	1	0.8	—	—
Multiple (more than one category)	3	2.5	—	—
Prefer not to say	4	3.3	—	—

Note. Los Angeles County Department of Child and Family Services (DCFS) provided the data on Los Angeles County youth who were in foster care in July 2021. Comparable data on the gender identities and sexual orientation of youth in foster care were not available. DCFS provided a distribution by age rather than average.

— Not available.

[a] The estimate of the average age for Los Angeles County youth ages 12–20 is a weighted average based on the midpoints of the age categories (12.99 for the youngest category, 15 for the middle category, and 18.99 for the oldest category).

The demographic results also indicated some associations among these characteristics. First, Latina or Latino youth tended to be younger than youth of other racial and ethnic backgrounds: the average age of Latina or Latino youth in foster care was 15 years old, compared with an average age of 17 years old among youth in other racial and ethnic groups. Second, youth age and gender identity were associated with their sexual orientation. Youth who reported they were straight (heterosexual) were about one year younger, on average, than other youth. The vast majority of male youth (92%) identified as straight (heterosexual), compared with a smaller majority (76%) of female youth.

To attempt to assess the representativeness of the survey sample, analysts requested data from DCFS, which maintains data on Los Angeles youth in foster care. The DCFS data system does not routinely measure gender identity, so 84% of youth had missing values on that variable. DCFS did not provide data on language or sexual orientation. Compared with all Los Angeles County youth in foster care, survey sample youth were about the same age (16 years old), on average. About 60% of both the survey sample and all Los Angeles County youth in care identified as Latina or Latino. Although the survey sample included lower percentages of youth who identified as members of Black, white, and other racial groups than DCFS reported for the population of Los Angeles County youth in care, the differences between the two groups are partly due to the fact that the survey allowed students to choose more than racial or ethnic group.

IV. Results From 2021

The 2021 survey included three topics also covered by the 2019 survey: social worker communication and support, youth's sources of SRH information, and the barriers they experienced in accessing SRH information or care. In addition to these topics, the 2021 survey asked questions related to youth access to social work support and SRH information and care in the past year, that is, during the COVID-19 pandemic, relative to previous years. In light of the differences between the 2019 and 2021 survey administrations, a separate chapter discusses differences between the two surveys' results.

For each of these topics, results are presented by youth demographic characteristics to assess whether there were systematic differences among youth by age, race and ethnicity, gender identity, and sexual orientation. Given the observed associations among some of these characteristics, authors conducted multivariate analyses to estimate the effect of each characteristic on youth responses to survey items independent of the effects of the other demographic characteristics. For example, youth who were older were also more likely to identify as a sexual orientation other than straight (heterosexual). To assess whether differences by age or sexual orientation were artifacts of the association between the two variables, multivariate analyses estimated the independent effects of each variable.

The multivariate analyses produce odds ratios, statistics that compare the odds of one group reporting an outcome with the odds of another group reporting the same outcome. Within each characteristic, for example, age group, analysts chose one group as the reference group and compared other groups to it. For example, analysts chose youth who were 17 through 20 years old as the reference group, and for each outcome they compared the odds of youth in the younger age groups having the outcome to the odds of youth 17 through 20 years old having the outcome. Limited sample sizes in some groups and limited variability in the data made multivariate analysis impossible in some cases. This section reports those results when multivariate analysis was possible and the net effects were statistically significant.

Part One: Social Worker Communication and Support

This section of the study addressed the following questions, each of which pertains to the implementation of CFYSHEA:

A. Do youth ages 12–20 who have been in foster care for at least one year remember having conversations with their social workers about sexual health during that year, and if so, do they remember being informed of their rights to sexual health information, access to services, and confidentiality regarding SRH?

B. Do youth ages 12–20 who have been in foster care for at least one year report that their social workers provided information on how to access SRH services or helped them access such services?

A: Do youth report having SRH conversations with social workers?

The law specifically requires that, each year, social workers speak with youth about their rights to (a) age-appropriate SRH information when they want it, (b) consent and access to SRH services, and (c) confidentiality regarding SRH information and services. Only 36% of participating youth reported that their social worker asked whether they had questions or wanted information about puberty, sex, or SRH; 31% reported that their social worker had let them know they have a right to have questions answered and get information from a reliable source; 27% reported they were told of their right to SRH care; and no participant reported their social worker informed them of their right to confidentiality (Table 2A).

In addition to these topics, which the law requires social workers to discuss with youth in foster care, the survey included items related to specific SRH concerns. Overall, 56% of youth reported having at least one conversation with a social worker about at least one of these SRH topics in the past year. Less than half of sampled youth in foster care reported that their social worker had discussed birth control or condoms (42% each) with them. Only 18% reported having discussed how to know when they are ready to have sex. No participant reported having spoken with their social worker about unplanned pregnancy or how to know if a relationship is healthy, and only one youth indicated that his social worker had discussed other, unspecified SRH topics with him, in his case "[being] too young to take care of a child" (Appendix B, Table B1).

Table 2A
Talking About Sexual Health Topics

Has your social worker talked with you about	*N*	Percent
Condoms	50	42.4
Birth control (other than condoms)	49	41.5
Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health	38	35.8
STDs/STIs (sexually transmitted diseases and infections)	40	34.5
Your right to have questions answered and get info from a reliable source	32	30.8
Your right to get sexual and reproductive health care when you want it	26	26.8
How to handle pressure to have sex	22	19.3
How to know when you are ready to have sex	20	17.5
Abortion	16	13.8
How to know if a relationship is healthy	0	0.0
Unplanned pregnancy	0	0.0
Your right to confidentiality/privacy about your sexual and reproductive health	0	0.0
Other topics?		
No	123	99.2
Yes	1	0.80

Older youth more often than younger youth reported having conversations with their social workers about SRH topics. Only 24% of 12- and 13-year-olds remembered a conversation in the

last year about at least one of the included topics, compared with 61% of 14- through 16-year-olds and 67% of 17- through 20-year-olds.

The data indicate similar age differences regarding the content covered by conversations when they did occur. Compared with 12- and 13-year-olds, youth aged 14–20 were at least five times more likely to report conversations about birth control, condoms, and STIs (Table 2B).

Table 2B
Talking About Sexual Health Topics, Results by Age

Has your social worker talked with you about	Ages 12–13		Ages 14–16		Ages 17–20		
	N = 25	Percent	*N* = 41	Percent	*N* = 58	Percent	*p* value
Condoms	2	8.3	18	47.4	30	53.6	<0.001
Birth control (other than condoms)	2	8.0	19	51.4	28	50.0	<0.001
Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health	4	18.2	17	48.6	17	34.7	0.065
STDs/STIs (sexually transmitted diseases and infections)	2	8.0	16	44.4	22	40.0	0.006
Your right to have questions answered and get info from a reliable source	4	18.2	11	34.4	17	34.0	0.35
Your right to get SRH care when you want it	2	9.1	8	28.6	16	34.0	0.09
How to handle pressure to have sex	2	8.3	7	18.4	13	25.0	0.23
How to know when you are ready to have sex	2	8.7	6	16.7	12	21.8	0.38
Abortion	1	4.0	4	10.8	11	20.4	0.12

After accounting for the effects of race and ethnicity, gender identity, and sexual orientation, the odds that 12- and 13-year-olds reported that their social worker had talked with them about condoms, other birth control, or STD or STIs were 90% lower than those of 17- through 20-year-olds.

There were no statistically significant differences by self-identified race and ethnicity in whether social workers had talked with youth about the SRH topics included in the survey (Table 2C).

Table 2C
Talking About Sexual Health Topics, Results by Race and Ethnicity

Has your social worker talked with you about	Latina or Latino		African-American or Black		White, Other, or Multiple[a]		
	N = 69	Percent	*N* = 20	Percent	*N* = 26	Percent	*p* value
Condoms	26	40.0	10	50.0	11	45.8	0.7
Birth control (other than condoms)	25	38.5	10	50.0	12	48.0	0.47
STDs/STIs (sexually transmitted diseases and infections)	22	33.8	10	50.0	6	27.3	0.28
Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health	19	33.3	9	47.4	9	40.9	0.52
Your right to have questions answered and get info from a reliable source	15	25.9	6	35.3	9	39.1	0.45
Your right to get sexual and reproductive health care when you want it	13	24.5	6	33.3	5	27.8	0.76
How to know when you are ready to have sex	10	16.1	5	25.0	4	16.7	0.66
How to handle pressure to have sex	9	14.5	5	26.3	5	20.8	0.47
Abortion	6	9.1	5	26.3	3	12.5	0.14

[a] The numbers of youth identifying as white, other, and multiple races or ethnicities were so small that it was necessary to combine the categories to create a sufficient number of cases for analysis.

Two gender identity differences were evident before and after controlling for other demographic characteristics. Relatively fewer male than female youth reported that their social workers spoke with them about birth control other than condoms (26% of males compared with 58% of females) and their right to SRH care when they want it (13% of males compared with 42% of females) (Table 2D). Controlling for age, race and ethnicity, and sexual orientation, males' odds of having had conversations with their social workers about these topics were 80% lower than those of females.

Table 2D

Talking About Sexual Health Topics, Results by Gender Identity and Sexual Orientation

Has your social worker talked with you about	Gender Identity[a]					Sexual Orientation				
	Female		Male			Straight (heterosexual)		Other[b]		
	N = 64	Percent	*N* = 52	Percent	*p* value	*N* = 100	Percent	*N* =18	Percent	*p* value
Condoms	28	47.5	21	41.2	0.51	43	45.3	6	35.3	0.45
Birth control (other than condoms)	35	58.3	13	26.0	<0.001	38	40.0	10	55.6	0.22
Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health	23	18.2	13	31.0	0.3	32	38.6	5	29.4	0.48
STDs/STIs (sexually transmitted diseases and infections)	23	38.3	17	35.4	0.76	32	34.4	6	35.3	0.94
Your right to have questions answered and get info from a reliable source	19	35.8	12	27.9	0.41	26	31.3	4	26.7	0.72
Your right to get sexual and reproductive health care when you want it	21	42.0	5	12.5	0.002	20	26.0	4	28.6	0.84
How to handle pressure to have sex	15	26.3	7	14.3	0.13	16	17.2	4	28.6	0.38
How to know when you are ready to have sex	13	22.0	5	10.6	0.12	16	17.8	3	16.7	0.91
Abortion	11	18.3	5	10.2	0.23	11	11.7	3	18.8	0.43

[a] Responses reflect self-identified gender identity of the respondents. Since only four respondents identified as a gender other than female or male, too few for statistical analysis, these results were not included here. See Table 1 for gender identity breakdown.
[b] Includes those who identified as asexual, bisexual, gay, lesbian, pansexual, questioning, unsure, multiple, or prefer not to say. It was necessary to combine these categories to create a sufficient number of cases for analysis. See Table 1 for sexual orientation breakdown.

In contrast to the gender identity results, there were no statistically significant differences between straight (heterosexual) youth and their peers who reported other sexual orientations.

B: Do youth report they received support accessing SRH information and services from social workers?

The survey asked whether youth remembered their social workers talking to them about how to access specific SRH services and information and whether their social workers helped them obtain access to specific services. Overall, no more than 17% of youth reported that their social workers had spoken with them about how they or their partners could access any of the following services: STI testing and treatment (14%), abortion (11%), and where to get more information about any of the topics included in the questions (17%) (Table 3A). No youth reported speaking with their social workers about how to access birth control, condoms, information about choices when someone is

pregnant, or prenatal care. In addition, no more than 14% of youth reported getting help from their social workers to access SRH services.

Table 3A
Talking About How to Obtain Information or Services and Receiving Help to Access Services

Has your social worker talked about how you/your partner can access these services or information?	*N*	Percent
Birth control	0	0.0
Condoms	0	0.0
STD/STI (sexually transmitted disease or infection) testing or treatment	16	13.9
Information about choices and next steps when someone is pregnant	0	0.0
Abortion	13	11.0
Prenatal care	0	0.0
Where to get more information about any of the topics just listed	17	16.5
Has your social worker helped you get access to these resources?		
Birth control	12	10.4
Condoms	16	13.7
STD testing or treatment	10	8.5
Pregnancy care (pregnancy testing, prenatal care, abortion, birthing support)	12	10.3

Although older youth were two to four times more likely than younger youth to report having received information from their social workers on how to access services and information, these differences were not statistically significant (Table 3B). Older youth were more likely to report having received help accessing condoms, however, 23% of 17- through 20-year-olds reported their social workers had helped them access condoms, compared with less than 5% of younger youth. This difference manifested in the multivariate analyses as well: the odds that their social workers helped them obtain condoms were 80% lower for 14- through 16-year-olds than for 17- through 20-year-olds.

Table 3B

Talking About How to Obtain Information or Services and Receiving Help to Access Services, Results by Age

Has your social worker talked about how you/your partner can access these services/ information?	12–13 Years Old		14–16 Years Old		17–20 Years Old		
	N = 25	Percent	*N* = 41	Percent	*N* = 58	Percent	*p* value
STD/STI (sexually transmitted disease or infection) testing or treatment	1	4.2	4	11.1	11	20.0	0.15
Abortion	1	4.0	3	8.1	9	16.1	0.22
Where to get more information about any of the topics I just listed	2	8.7	5	16.7	10	20.0	0.48
Has your social worker helped you get access to these resources?							
Birth control	1	4.3	2	5.4	9	16.4	0.14
Condoms	1	4.3	2	5.3	13	23.2	0.016
STD/STI testing or treatment	0	0.0	2	5.3	8	14.3	0.081
Pregnancy care (pregnancy testing, prenatal care, abortion, birthing support)	0	0.0	3	8.1	9	15.8	0.095

Thirty percent of African-American or Black youth reported that their social workers had talked with them about how to access STI testing or treatment, compared with 17% or less of youth in other racial/ethnic groups (Table 3C). In addition, relatively fewer Latina or Latino youth (7%) than other youth (about one-quarter of African-American or Black youth and one-third of youth in other racial/ethnic groups) reported that their social workers had talked with them about how to access more information about SRH topics. These differences were not apparent in the multivariate analyses, however, which may indicate they are less a function of race and ethnicity than of other related factors.

Table 3C

Talking About How to Obtain Information or Services and Receiving Help to Access Services, Results by Race and Ethnicity

Has your social worker talked about how you/your partner can access these services/ information?	Latina or Latino		African-American or Black		White, Other, or Multiple[a]		
	N = 69	Percent	*N* = 20	Percent	*N* = 26	Percent	*p* value
STD/STI (sexually transmitted disease or infection) testing or treatment	5	7.8	6	30.0	4	17.4	0.039
Abortion	4	6.1	5	25.0	3	12.5	0.057
Where to get more information about any of the topics I just listed	4	7.0	4	23.5	8	33.3	0.009
Has your social worker helped you get access to these resources?							
Birth control	6	9.1	1	5.4	4	18.2	0.35
Condoms	6	9.2	5	25	4	16.7	0.18
STD testing or treatment	5	7.7	2	10.0	2	8.3	0.95
Pregnancy care (pregnancy testing, prenatal care, abortion, birthing support)	6	9.2	2	10.0	3	12.5	0.9

[a] The numbers of youth identifying as white, other, and multiple races or ethnicities were so small that it was necessary to combine the categories to create a sufficient number of cases for analysis.

Youth's responses to whether their social workers had spoken with them about accessing information or services or helped them access services did not vary with gender identity or sexual orientation (Table 3D).

Table 3D

Talking About How to Obtain Information or Services and Receiving Help to Access Services, Results by Gender Identity and Sexual Orientation

Has your social worker talked about how you/your partner can access these services/ information?	Gender Identity[a]					Sexual Orientation				
	Female		Male			Straight-(heterosexual)		Other[b]		
	N = 64	Percent	*N* = 52	Percent	*p* value	*N* = 100	Percent	*N* = 18	Percent	*p* value
STD/STI (sexually transmitted disease or infection) testing or treatment	10	17.7	6	12.0	0.42	13	14	2	11.8	0.81
Abortion	8	13.3	5	9.8	0.56	10	10.4	2	11.8	0.87
Where to get more information about any of the topics I just listed	10	18.5	7	17.1	0.86	13	15.9	3	18.8	0.77
Has your social worker helped you get access to these resources?										
Birth control	9	15.3	3	6.3	0.14	9	9.6	2	12.5	0.72
Condoms	11	18.0	5	10.4	0.26	11	11.6	4	23.5	0.18
STD testing or treatment	7	11.7	3	6.1	0.32	8	8.4	1	5.9	0.72
Pregnancy care (pregnancy testing, prenatal care, abortion, birthing support)	9	14.8	3	6.1	0.15	8	8.4	2	11.8	0.66

[a] Responses reflect self-identified gender identity of the respondents. Since only four respondents identified as a gender other than female or male, too few for statistical analysis, these results were not included here. See Table 1 for gender identity breakdown.
[b] Includes those who identified as asexual, bisexual, gay, lesbian, pansexual, questioning, unsure, multiple, or prefer not to say. It was necessary to combine these categories to create a sufficient number of cases for analysis. See Table 1 for sexual orientation breakdown.

Part Two: Sources of Sexual and Reproductive Health Information

Youth can receive SRH information and support from many sources other than social workers: Family can play an important role in this regard, as can schools, caregivers, and health providers. In order to increase their comfort and skills in providing support to young people in their charge, CFYSHEA requires that adults seeking to become licensed as "resource parents"[2] receive information and training on healthy sexual development. In addition, the California Healthy Youth Act requires California public and charter schools to provide comprehensive sexual health education using a curriculum that meets state standards at least once in middle school and once in high school. CFYSHEA requires social workers to confirm that youth have received school-based sexual health education and, if they have not, to connect them to a comparable curriculum in the community.

[2] "Resource parents" is California's term for foster parents that includes foster, foster-to-adopt, and kinship caregivers. See https://www.childwelfare.gov/topics/permanency/recruiting.

About half of youth in foster care had received information on birth control, STD/STI treatment, or pregnancy at school (52%) or from friends (53%) in the last year. Just under a third (30%) had received such information from their caregivers. About one-fifth reported receiving such information from parents or relatives (20%) or health care providers (22%) (Table 4A).

Table 4A
Sources of Information

Have you received information on birth control, condoms, sexually transmitted disease or infection treatment, or pregnancy from these sources in the past year?	*N*	Percent
School	65	52.4
Caregivers	27	21.8
Friends	66	53.2
Family (parents or relatives)	25	20.2
Health care providers	37	29.8

Youth's reports of their sources of information varied with their age. Youth aged 17–20 were two to three times as likely as 12- through 16-year-olds to have received information on birth control, condoms, STD/STI treatment, or pregnancy from caregivers, family, and health care providers (Table 4B).

Table 4B
Sources of Information, Results by Age

Have you received information on birth control, condoms, sexually transmitted disease or infection treatment, or pregnancy from these sources in the past year?	12–13 Years Old		14–16 Years Old		17–20 Years Old		
	N = 25	Percent	*N* = 41	Percent	*N* = 58	Percent	*p* value
School	9	36.0	25	61.0	31	53.4	0.14
Caregivers	3	12.0	5	12.2	19	32.8	0.021
Friends	9	36.0	23	56.1	34	58.6	0.15
Family (parents or relatives)	2	8.0	3	7.3	20	34.5	<0.001
Health care providers	4	16.0	8	19.5	25	43.1	0.01

Multivariate analyses indicated that age was consistently associated with differences in youth's access to information about birth control, condoms, STD/STI treatment, or pregnancy. Younger youth were consistently less likely than the oldest youth to report that they had received information from all sources except school. For each of these four information sources, either or both of the two younger groups had 70% to 89% lower odds of obtaining information about these topics when compared with the oldest youth.

Compared with youth of other racial/ethnic backgrounds, those who identified as Latina or Latino reported receiving information about these selected SRH topics from family members less often: 15% of Latina or Latino youth, compared with 35% of African-American or Black youth and 31%

of youth who identified with other racial/ethnic groups (Table 4C). On the other hand, whereas 62% of Latina or Latino youth reported receiving such information from friends, 50% or less of non-Latina or Latino youth reported their friends were sources of SRH information. This latter difference was also observed in the multivariate analyses: the odds that a Latina or Latino youth reported receiving information from friends were five times greater than the odds that youth who identified as white, another non-Black racial/ethnic group, or multiple racial/ethnic backgrounds did so.

Table 4C

Sources of Information, Results by Race and Ethnicity

Have you received info on birth control, condoms, sexually transmitted disease or infection treatment, or pregnancy from these sources?	Latina or Latino		African-American or Black		White, Other, or Multiple[a]		*p* value
	N = 69	Percent	*N* = 20	Percent	*N* = 26	Percent	
School	38	55.1	11	55.0	12	46.2	0.73
Caregivers	17	24.6	3	15.0	6	23.1	0.66
Friends	43	62.3	10	50.0	10	38.5	0.1
Family (parents or relatives)	10	14.5	7	35.0	8	30.8	0.066
Health care providers	19	27.5	7	35.0	11	42.3	0.37

[a] The numbers of youth identifying as white, other, and multiple races or ethnicities were so small that it was necessary to combine the categories to create a sufficient number of cases for analysis.

There were no statistically significant differences in youth's reports regarding these sources of SRH information by gender identity or sexual orientation (Table 4D).

Table 4D

Sources of Information, Results by Gender Identity and Sexual Orientation

Have you received info on birth control, condoms, sexually transmitted disease or infection treatment, or pregnancy from these sources?	Gender Identity[a]					Sexual Orientation				
	Female		Male			Straight (heterosexual)		Other[b]		
	N = 64	Percent	*N* = 52	Percent	*p* value	*N* = 100	Percent	*N* = 18	Percent	*p* value
School	37	57.8	25	48.1	0.3	53	53.0	10	55.6	0.84
Caregivers	17	26.8	8	15.4	0.15	24	24.0	2	11.1	0.22
Friends	35	54.7	29	55.8	0.91	53	53.0	13	72.2	0.13
Family (parents or relatives)	15	23.4	8	15.4	0.28	20	20.0	4	22.2	0.83
Health care providers	21	32.8	14	26.9	0.49	28	28.0	9	50.0	0.064

[a] Responses reflect self-identified gender identity of the respondents. Since only four respondents identified as a gender other than female or male, too few for statistical analysis, these results were not included here. See Table 1 for gender identity breakdown.
[b] Includes those who identified as asexual, bisexual, gay, lesbian, pansexual, questioning, unsure, multiple, or prefer not to say. It was necessary to combine these categories to create a sufficient number of cases for analysis. See Table 1 for sexual orientation breakdown.

Part Three: Barriers to Sexual Health Information, Services, and Support

Questions in part two of the survey asked youth whether they had received SRH information from their social workers and other sources regardless of whether they had sought such information. In part three, the survey asked youth whether they had experienced challenges in obtaining the following SRH-related information, resources, or services: basic information about puberty, sex, or pregnancy; condoms; other forms of birth control for themselves or their partners; STD/STI testing or treatment; pregnancy testing or prenatal care; and abortion services. No more than 7% of youth reported having trouble getting access to any of these resources.

These small numbers may seem reassuring, but it is important to note that youth did not report whether they had tried to obtain any of these resources: the small numbers may indicate that youth experience challenges before attempting to access resources. Indeed, when asked whether nine common barriers to SRH information and resources were problems for them, considerably larger numbers of youth reported encountering one or more. More than one-third (37%) of youth reported feeling uncomfortable discussing sex and reproductive health care with adults. About one-tenth reported experiencing two other barriers: not being able to see a health care provider with whom they felt comfortable (10%) and being concerned that others would learn about their requests (9%). Notably, very few reported that their caregiver or group home refused or limited their access to information or services.

In addition to the nine specific barriers reported in Table 5A, the survey asked whether youth experienced other barriers and, if so, what they were. Four youth mentioned additional barriers: an 18-year-old's partner presented a barrier to her accessing birth control, and three others noted that accessing money to buy condoms or a pregnancy test was a problem (Appendix B, Table B2). Two of these latter three youth were also concerned about others knowing they were accessing these resources.

Table 5A

Challenges in Accessing Information and Care Related to Sexual and Reproductive Health

Have you ever had trouble getting access to any of these resources?	*N*	Percent
Basic information about puberty, sex, or pregnancy	5	4.0
Birth control for you or a partner	5	4.0
Condoms	8	6.5
Testing or treatment for sexually transmitted infections or diseases (STIs or STDs)	4	3.2
Prenatal care or pregnancy testing	5	4.0
Abortion services	2	1.6
What makes it hard for you to get health care or information about sex?	***N***	Percent
My caregiver/home/STRTP refused to provide transportation to get resources or services	2	1.6
I was not able to go to a health care provider I feel comfortable with	13	10.5
I feel uncomfortable talking about sex and reproductive health care with adults	46	37.1
I was concerned about someone finding out	11	8.9
I don't have insurance or don't know how I would pay for it	1	0.8
My caregiver doesn't know my sexual orientation and I don't want to tell them	5	4.0
I didn't know who to ask for information or where to find information online	1	0.8
My group caregiver/home/STRTP wouldn't let me go	2	1.6
My group caregiver/home/STRTP doesn't allow people to have birth control	2	1.6

Note. STRTP = short-term residential therapeutic program.

There were no statistically significant differences among age groups in the percentage of youth who reported trouble accessing any of the six resources named in the survey (Table 5B). In response to the questions about potential barriers to accessing SRH information, resources, or services, 46%–48% of youth 12–16 years old reported that they were uncomfortable talking about SRH care with adults, compared with 26% of 17- through 20-year-olds.

Table 5B

Challenges in Accessing Information and Care Related to Sexual and Reproductive Health, Results by Age

Have you have ever had trouble getting access to any of these resources?	12–13 Years Old		14–16 Years Old		17–20 Years Old		
	N = 25	Percent	*N* = 41	Percent	*N* = 58	Percent	*p* value
Basic information about puberty, sex, or pregnancy	2	8.0	1	2.4	2	3.4	0.51
Birth control for me or a partner	2	8.0	0	0.0	3	5.2	0.23
Condoms	2	8.0	3	7.3	3	5.2	0.86
Testing or treatment for sexually transmitted infections or diseases (STIs or STDs)	1	4.0	1	2.4	2	3.4	0.93
Prenatal care or pregnancy testing	1	4.0	1	2.4	3	5.2	0.79
Abortion services	1	4.0	0	0.0	1	1.7	0.46
What makes it hard for you to get health care or information about sex?							
My caregiver/home/STRTP refused to provide transportation to resources/services	0	0.0	1	2.4	1	1.7	0.74
I was not able to go to a health care provider I feel comfortable with	4	16.0	6	14.6	3	5.2	0.19
I feel uncomfortable talking about sex and reproductive health care with adults	12	48.0	19	46.3	15	25.9	0.052
I was concerned about someone finding out	1	4.0	7	17.1	3	5.2	0.077
I don't have insurance or don't know how I would pay for it	0	0.0	1	2.4	0	0.0	0.36
My caregiver doesn't know my sexual orientation and I don't want to tell them	1	4.0	3	7.3	1	1.7	0.38
I didn't know who to ask for information or where to find information online	0	0.0	1	2.4	0	0.0	0.36
My group caregiver/home/STRTP wouldn't let me go	0	0.0	1	2.4	1	1.7	0.74
My group caregiver/home/STRTP doesn't allow people to have birth control	0	0.0	1	2.4	1	1.7	0.74

Note. STRTP = short-term residential therapeutic program.

There were no statistically significant differences by race and ethnicity in whether youth had had trouble accessing any of six resources or in whether they found any of the nine potential barriers to be a problem for them (Table 5C). Similarly, there were no statistically significant differences by youth's gender identity (Table 5D).

Table 5C

Challenges in Accessing Information and Care Related Sexual and Reproductive Health, Results by Race and Ethnicity

Have you have ever had trouble getting access to any of these resources?	Latina or Latino		African-American or Black		White, Other, or Multiple[a]		*p* value
	N = 69	Percent	*N* = 20	Percent	*N* = 26	Percent	
Basic information about puberty, sex, or pregnancy	3	4.3	0	0.0	2	7.7	0.45
Birth control for me or a partner	3	4.3	0	0.0	2	7.7	0.45
Condoms	4	5.8	0	0.0	2	7.7	0.48
Testing or treatment for sexually transmitted infections or diseases (STIs or STDs)	2	2.9	0	0.0	2	7.7	0.34
Prenatal care or pregnancy testing	2	2.9	0	0.0	3	11.5	0.11
Abortion services	1	1.4	0	0.0	1	3.8	0.59
What makes it hard for you to get health care or information about sex?							
My caregiver/home/STRTP refused to provide transportation to resources/services	0	0.0	1	5.0	1	3.8	0.21
I was not able to go to a health care provider I feel comfortable with	10	14.5	2	10.0	1	3.8	0.34
I feel uncomfortable talking about sex and reproductive health care with adults	31	44.9	6	30.0	7	26.9	0.19
I was concerned about someone finding out	7	10.1	1	5.0	2	7.7	0.76
I don't have insurance or don't know how I would pay for it	1	1.4	0	0.0	0	0.0	0.71
My caregiver doesn't know my sexual orientation and I don't want to tell them	4	5.8	0	0.0	1	3.8	0.53
I didn't know who to ask for information or where to find information online	1	1.4	0	0.0	0	0.0	0.71
My group caregiver/home/STRTP wouldn't let me go	1	1.4	1	5.0	0	0.0	0.42
My group caregiver/home/STRTP doesn't allow people to have birth control	1	1.4	1	5.0	0	0.0	0.42

Note. STRTP = short-term residential therapeutic program.
[a] The numbers of youth identifying as white, other, and multiple races or ethnicities were so small that it was necessary to combine these categories to create a sufficient number of cases for analysis.

Table 5D

Challenges in Accessing Information and Care Related to Sexual and Reproductive Health, Results by Gender Identity

Have you have ever had trouble getting access to any of these resources?	Female		Male		*p* value
	N = 64	Percent	*N* = 52	Percent	
Basic information about puberty, sex, or pregnancy	3	4.7	2	3.8	0.82
Birth control for me or a partner	4	6.3	1	1.9	0.25
Condoms	4	6.3	4	7.7	0.76
Testing or treatment for sexually transmitted infections or diseases (STIs or STDs)	2	3.1	2	3.8	0.83
Prenatal care or pregnancy testing	3	4.7	2	3.8	0.82
Abortion services	2	3.1	0	0.0	0.20
What makes it hard for you to get health care or information about sex?					
My caregiver/home/STRTP refused to provide transportation to resources/services	1	1.6	1	1.9	0.88
I was not able to go to a health care provider I feel comfortable with	7	10.9	4	7.7	0.55
I feel uncomfortable talking about sex and reproductive health care with adults	19	29.7	24	46.2	0.068
I was concerned about someone finding out	8	12.5	2	3.8	0.099
I don't have insurance or don't know how I would pay for it	0	0.0	0	0.0	
My caregiver doesn't know my sexual orientation and I don't want to tell them	3	4.7	1	1.9	0.42
I didn't know who to ask for information or where to find information online	0	0.0	0	0.0	
My group caregiver/home/STRTP wouldn't let me go	1	1.6	0	0.0	0.37
My group caregiver/home/STRTP doesn't allow people to have birth control	1	1.6	0	0.0	0.37

Note. Responses reflect self-identified gender identity of the respondents. Since only four respondents identified as a gender other than female or male, too few for statistical analysis, these results were not included here. See Table 1 for gender identity breakdown. STRTP = short-term residential therapeutic program.

About one-fifth (22%) of nonheterosexual youth reported that not wanting to reveal their sexual orientation to their caregivers posed a barrier to accessing SRH health care or information (Table 5E). Not surprisingly, only 1% of straight (heterosexual) youth agreed with this statement.

Table 5E

Challenges in Accessing Information and Care Related to Sexual and Reproductive Health, Results by Sexual Orientation

Have you have ever had trouble getting access to any of these resources?	Straight (heterosexual)		Other[a]		*p* value
	N = 100	Percent	*N* = 18	Percent	
Basic information about puberty, sex, or pregnancy	4	4.0	1	5.6	0.76
Birth control for me or a partner	4	4.0	1	5.6	0.76
Condoms	7	7.0	1	5.6	0.82
Testing or treatment for STDs/STIs (sexually transmitted diseases or infections)	4	4.0	0	0.0	0.39
Prenatal care or pregnancy testing	5	5.0	0	0.0	0.33
Abortion services	2	2.0	0	0.0	0.55
What makes it hard for you to get health care or information about sex?					
My caregiver/home/STRTP refused to provide transportation to resources/services	2	2.0	0	0.0	0.55
I was not able to go to a health care provider I feel comfortable with	9	9.0	4	22.2	0.099
I feel uncomfortable talking about sex and reproductive health care with adults	40	40.0	6	33.3	0.59
I was concerned about someone finding out	8	8.0	3	16.7	0.24
I don't have insurance or don't know how I would pay for it	1	1.0	0	0.0	0.67
My caregiver doesn't know my sexual orientation and I don't want to tell them	1	1.0	4	22.2	<0.001
I didn't know who to ask for information or where to find information online	1	1.0	0	0.0	0.67
My group caregiver/home/STRTP wouldn't let me go	2	2.0	0	0.0	0.55
My group caregiver/home/STRTP doesn't allow people to have birth control	2	2.0	0	0.0	0.55

Note. STRTP = short-term residential therapeutic program.
[a] Includes those who identified as asexual, bisexual, gay, lesbian, pansexual, questioning, unsure, multiple, or prefer not to say. It was necessary to combine these categories to create a sufficient number of cases for analysis. See Table 1 for sexual orientation breakdown.

V. Comparing 2019 and 2021 Results

This study was designed to repeat survey administrations over time in order to establish whether youth in foster care experienced greater access to SRH-related information, resources, and services as CFYSHEA implementation presumably became more robust. In this design, the 2019 survey results would serve, to some degree, as a baseline against which subsequent administrations' results could be compared to identify whether progress is occurring, how quickly, and whether there are significant gaps in progress by type of information or service or by youth characteristics.

As it did in so many aspects of life, the COVID-19 pandemic disrupted the efficacy of this design, making the ability to compare the results between the 2019 and 2021 surveys tenuous in several ways. First, the methods differed between the two surveys. In 2019 interviewers met with youth in person while the youth were in court waiting for a dependency hearing, but in 2021, interviewers conducted interviews via telephone or video conference. To the degree that youth were unable to access telephones or Internet connections in private locations, their comfort and candor during the interviews may have been compromised.

The sample selection process also differed between the two survey administrations. In both 2019 and 2021, CLC staff generated a list of youth who met eligibility criteria, that is, those who were between 12 and 20 years old and had been in foster care for at least one year. In 2019, CLC then identified youth whose cases were scheduled for routine court hearings on each weekday during the six-week study period. Interviewers obtained permission from the youth's attorneys to invite the youth to participate in the study. Once they had received permission and while these youth were waiting for their hearings to begin, interviewers informed youth of the study and their right not to participate before asking them whether they would be willing to take the survey. In contrast, in 2021, CLC staff divided the names of youth who met eligibility criteria among the four interviewers, who then contacted the youth's attorneys for permission to ask youth to participate. No attorney denied permission. Interviewers then attempted to contact youth to obtain consent and conduct the interviews via either telephone or video. In some cases, caregivers prevented interviewers from reaching youth directly. In others, youth were reluctant to spend time on the phone once school adjourned for the summer.

Whether related to these sampling and recruiting process differences, the direct impact of the COVID-19 pandemic, or other factors, the 2021 survey's sample was only one-quarter of the 2019 survey's sample, raising the question of nonresponse bias. Fortunately, the demographic distributions of the 2019 and 2021 samples are very similar (Table 6), providing some reassurance that nonresponse bias may not be large. Nevertheless, the smaller number of youth in 2021 make those estimates less stable; therefore, detecting differences between the two periods is more difficult than it would have been with a larger 2021 sample.

Table 6
Demographics: 2019 and 2021 Survey Samples

Characteristic	2019		2021	
	N	Percent	*N*	Percent
N	513	100.0	124	100.0
Age in years [mean(*SD*)]	15.5	2.3	16.2	2.5
Race and ethnicity				
African-American or Black	86	17.2	20	17.4
Latina or Latino	300	60.1	69	60.0
White or Caucasian	17	3.4	9	7.8
Arab or Middle Eastern	2	0.4	0	0.0
Asian	3	0.6	0	0.0
Pacific Islander	1	0.2	0	0.0
Other	5	1.0	1	0.9
Multiple races or ethnicities	85	17.0	16	13.9
Gender identity				
Female	283	55.4	64	53.3
Male	223	43.6	52	43.3
Nonbinary, gender fluid, gender nonconforming, or gender queer	1	0.2	3	2.5
Multiple (more than one category)	4	0.8	1	0.8
Sexual orientation				
Asexual	1	0.2	0	0.0
Bisexual	39	7.6	13	10.7
Gay	6	1.2	1	0.8
Straight (heterosexual)	435	85.0	100	82.0
Lesbian	7	1.4	0	0.0
Pansexual	4	1.2	0	0.0
Questioning or unsure	6	1.2	1	0.8
Multiple (more than one category)	1	0.2	3	2.5
Does not identify with any	1	0.2	0	0.0
Prefer not to say	12	2.3	4	3.3

Second, in addition to affecting the survey methods, the pandemic's effects on the lives of youth in care, their social workers, caregivers, health care providers, and school experiences were many, varied, and certainly extreme. The 2021 survey was conducted in July and August, as youth in Los Angeles were slowly emerging from almost a year under such pandemic-related public health measures as restricted travel, closed schools, and limited access to services. Child welfare agencies struggled to provide services and connect with families and youth during these restrictions. Moreover, the COVID-19 pandemic had significant impact on the physical and mental health and well-being of many people, especially children and youth. These and related disruptions may well have affected the 2021 responses relative to 2019 in a variety of ways: youth may have had less or more contact with their social workers during the crisis; youth may have had more or less contact with health care providers; even if the number of interactions was similar, whether they occurred in person or virtually could have affected responses; social workers may have had to manage more changes in youth's foster or school placements due to the pandemic, leaving less time for

conversations about SRH; both social workers and health care providers may have had more pressing issues to address; and so on.

To gain some understanding of how the circumstances of the pandemic may have affected youth's responses to the survey, the 2021 survey included questions about youth's access to such resources as their social workers, SRH services, and sex education in school during the last year, that is, during the pandemic. Between 53% and 58% of youth reported their access to each resource in the last year was similar to their access before the pandemic (Table 7). The remaining youth, however, were more likely to report *less* access to social workers, SRH services, and sex education during the pandemic than before it occurred (about 30% vs. 10%–16%). Only access to information on how to stay safe in relationships appeared to improve in the second year (27% vs. 19%). Reports of reduced access to social workers may have biased youth reports of access in other areas in a negative direction.

Table 7

Pandemic Effects on Access to Resources Relevant to Sexual and Reproductive Health

In the past year, since the pandemic started, have you had more or less access to	*N*	Percent
Your social worker/case worker?	119	
A lot less	14	11.9
Somewhat less	21	17.8
Same	64	54.2
More	11	9.3
A lot more	8	6.8
Information on how to stay safe in your relationships?	113	
A lot less	11	9.7
Somewhat less	11	9.7
Same	60	53.1
More	7	6.2
A lot more	24	21.2
I didn't want/try to access	0	0.0
Sexual and reproductive services such as appointments to get contraception/birth control, STD testing, prenatal care, abortion services?	112	
A lot less	19	17.0
Somewhat less	15	13.4
Same	65	58.0
More	7	6.3
A lot more	6	5.4
I didn't want/try to access	0	0.0
Sex ed through school, such as in a health, science, or other class?	111	
A lot less	20	18.0
Somewhat less	19	17.1
Same	61	55.0
More	7	6.3
A lot more	4	3.6
I didn't want/try to access	0	0.0

Youth reports about changes in resource access during the pandemic varied among demographic groups. Compared with the oldest youth, the two groups of younger youth were less likely to report that their access to social workers declined during the pandemic. On the other hand, younger youth were more likely than the oldest youth to report that they had less access to SRH services during the pandemic. Latina or Latino youth were three times as likely as youth who identified as white, other race and ethnicity, or of multiple races or ethnicities to report that they had less access to sex education in school.

After adjusting for confounding factors, males were three times more likely than females to report that they had less access to their social workers during the pandemic. Although the odds ratio estimates were not statistically significant, nonheterosexual youth were three to four times more likely than heterosexual youth to report less access to their social workers, information on staying safe in relationships, and SRH services during the pandemic. The very small sample of

nonheterosexual youth made detecting differences between them and other youth difficult, so the consistent pattern across three of the four resources is noteworthy.

The survey also asked youth whether each of the following five factors made it more difficult for them to access SRH services: finances or money, housing or placement, mental health, education, or employment. Across the five factors, between 63% and 85% of youth indicated that the factors did not make accessing services more difficult during the pandemic (Table 8). Multivariate analyses indicated that in general, younger youth were less likely than the oldest youth to report that finances, housing, or mental health reduced their access to SRH services during the pandemic. Notably, Latina or Latino youth were four times more likely than those who identified as white, other race and ethnicity, or of multiple races or ethnicities to report mental health as a barrier to accessing SRH services.

Table 8
Whether Various Factors Made Access to Sexual and Reproductive Health Services More Difficult During Pandemic: 2021

In the past year, since the pandemic started, have any of the following made it more difficult for you to access sexual and reproductive health services? Please say yes if it made it more difficult for you to get access.	*N*	Percent
Finances/money		
Yes	26	23.2
No	86	76.8
Housing/placement		
Yes	17	15.0
No	96	85.0
Mental health		
Yes	35	31.3
No	77	68.8
Education		
Yes	42	37.5
No	70	62.5
Employment		
Yes	23	20.7
No	88	79.3

Given the differences in methods between the two survey administrations and the pandemic-related disruptions to everyday life that occurred in 2020–21 (some of which are documented in the 2021 survey), the validity of direct comparisons between individual 2019 and 2021 estimates is suspect. Looking at patterns of differences, however, can be fruitful for reflecting on these data and planning for future research on the sexual development of youth in foster care and the implementation of CFYSHEA, including in the new context of an ongoing pandemic.

Among all youth, the percentages who reported having conversations with their social workers about the series of SRH topics more often increased than decreased between 2019 and 2021 (Table 9). Overall, 56% of youth surveyed in 2021 reported having at least one conversation about SRH topics with a social worker in the past year; 45% did so in 2019. Among the 12 specific SRH-related topics in the survey, the percentage of youth who reported they had discussed the topic with their social workers in the last year appears to have increased between 2019 and 2021 for nine of those topics.

Table 9
Talking About Sexual Health Topics: 2019 and 2021

Has your social worker talked with you about	2019		2021		Change From 2019
	N	Percent	*N*	Percent	
Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health	127	26.0	38	35.8	+
How to know if a relationship is healthy	117	23.4	0	0.0	−
How to know when you are ready to have sex	61	12.2	20	17.5	+
Birth control (other than condoms)	114	22.8	49	41.5	+
Condoms	132	26.1	50	42.4	+
Unplanned pregnancy	72	14.3	0	0.0	−
STDs/STIs (sexually transmitted diseases and infections)	103	20.5	40	34.5	+
How to handle pressure to have sex	68	13.4	22	19.3	+
Your right to get sexual and reproductive health care when you want it	109	21.9	26	26.8	+
Your right to confidentiality/privacy about your sexual and reproductive health	122	24.6	0	0.0	−
Your right to have questions answered and get info from a reliable source	115	23.0	32	30.8	+
Abortion	60	11.8	16	13.8	+
Are there any other sexual health topics you can think of that they talked to you about?					
No	504	98.2	123	99.2	~
Yes	9	1.8	1	0.8	~

CFYSHEA requires social workers to inform the youth whose cases they manage of their rights to access age-appropriate SRH information, to consent to care, and to confidentiality. The percentages of youth reporting that their social workers asked them whether they had questions or wanted information about puberty, sex, or SRH and that discussed youth's rights to have questions answered and get information from a reliable source and to obtain care were larger in 2021 than in 2019. On the other hand, no youth surveyed in 2021 reported their social worker had talked to them about their right to confidentiality, whereas 24% of youth surveyed in 2019 had done so.

In 2019, between 7% and 17% of youth reported having conversations with their social workers regarding access to information about five specific SRH resources or services or access to the

resources or services themselves (Table 10). In 2021, youth reported conversations with their social workers about only two of these five: 11% had conversations about abortion or abortion access, and 14% had conversations about accessing STD/STI testing or treatment information or access to those services. That no youth in 2021 reported discussing any of the other topics with their social workers is striking, especially in light of the consistent, if small, increases over time in the percentage of youth who reported that their social workers actually helped them access four specific SRH resources or services. These inconsistencies raise questions about how respondents understood the survey questions.

Table 10
Accessing Services and Information: 2019 and 2021

Has your social worker talked about how you/your partner can access these services or information?	2019		2021		Change From 2019
	N	Percent	*N*	Percent	
Birth control	67	13.2	0	0.0	−
Condoms	84	16.6	0	0.0	−
STD/STI (sexually transmitted disease or infection) testing or treatment	65	12.8	16	13.9	+
Information about choices and next steps when someone is pregnant	41	8.2	0	0.0	−
Abortion	37	7.4	13	11.0	+
Prenatal care	24	4.7	0	0.0	−
Where to get more information about any of the topics I just listed	59	11.5	17	16.5	+
Has your social worker helped you get access to these resources?					
Birth control	40	7.8	12	10.4	+
Condoms	50	9.8	16	13.7	+
STD testing or treatment	31	6.1	10	8.5	+
Pregnancy care (pregnancy testing, prenatal care, abortion, birthing support)	21	4.2	12	10.3	+

When asked whether they had received SRH-related information from each of five specific sources of information, fewer youth reported receiving information from their schools, caregivers, family, or health care providers in 2021 than in 2019 (Table 11). In contrast, relatively more youth reported receiving SRH-related information from friends in 2021 than in 2019 (53% compared with 37%, respectively). This pattern could reflect the disruptions in interactions caused by the pandemic.

Table 11
Sources of Information: 2019 and 2021

Have you received information on birth control, condoms, sexually transmitted disease treatment, or pregnancy from these sources?	2019		2021		Change From 2019
	N	Percent	*N*	Percent	
School	324	63.2	65	52.4	−
Caregivers	139	27.1	27	21.8	−
Friends	188	36.6	66	53.2	+
Family (parents or relatives)	204	39.8	25	20.2	−
Health care providers	212	41.3	37	29.8	−

When asked whether they had experienced difficulty accessing each of six specific SRH-related resources or services, small percentages (7% or less) of youth reported having had challenges in these areas in both 2019 and 2021 (Table 12). The 2021 percentages were larger than the corresponding 2019 percentages for four of the six resources/services, though given the small proportions, the magnitude of the difference was negligible in most cases.

Table 12
Challenges to Accessing Information, Resources, or Services: 2019 and 2021

Have you ever had trouble getting access to any of these resources?	2019		2021		Change From 2019
	N	Percent	*N*	Percent	
Basic information about puberty, sex, or pregnancy	27	5.3	5	4.0	−
Birth control for me or a partner	15	2.9	5	4.0	+
Condoms	15	2.9	8	6.5	+
Testing or treatment for STDs/STIs (sexually transmitted diseases or infections)	12	2.3	4	3.2	+
Prenatal care or pregnancy testing	9	1.8	5	4.0	+
Abortion services	10	1.9	2	1.6	−
What makes it hard for you to get health care or information about sex?					
My caregiver/home/STRTP refused to provide transportation to get resources or services	27	5.3	2	1.6	−
I was not able to go to a health care provider I feel comfortable with	47	9.2	13	10.5	+
I feel uncomfortable talking about sex and reproductive health care with adults	194	37.8	46	37.1	−
I was concerned about someone finding out	35	6.8	11	8.9	+
I don't have insurance or don't know how I would pay for it	16	3.1	1	0.8	−
My caregiver doesn't know my sexual orientation and I don't want to tell them	27	5.3	5	4.0	−
I didn't know who to ask for information or where to find information online	48	9.4	1	0.8	−
My group caregiver/home/STRTP wouldn't let me go	14	2.7	2	1.6	−
My group caregiver/home/STRTP doesn't allow people to have birth control	14	2.7	2	1.6	−

Note. STRTP = short-term residential therapeutic program.

Although relatively few youth reported experiencing challenges accessing specific SRH-related resources and services in either 2019 or 2021, more youth reported experiencing a few of nine potential barriers to obtaining SRH-related health care or information. For the most part differences between the 2019 and 2021 percentages were small, and seven of the nine differences were negative, indicating relatively fewer youth experienced these barriers in 2021 than in 2019. The largest difference was observed in the percentage of youth who agreed with the statement "I don't know who to ask for information or where to find information online." Nine percent of youth agreed with that statement in 2019, but 1% did so in 2021, one indication that information may have been more accessible to youth in 2021, when remote schooling resulted in some students acquiring new or better access to the Internet from home.

VI. Limitations of Study Design

In addition to the pandemic-related differences in survey methods and youth experience that complicate interpreting differences between 2019 and 2021 estimates, there are several limitations to this study, many of which apply to both the 2019 and 2021 survey administrations. First, the validity of the estimates of whether youth had the conversations of interest depends on youth accurately remembering the occurrence, timing, and content of those conversations. Given the limits of human memory, the study results are likely to underestimate the percentage of youth who actually had conversations with social workers or others about specific topics: youth are more likely to forget a conversation than remember one that did not happen. Moreover, as stress can affect memory and recall, this recall bias may have been exacerbated by the COVID-19 pandemic and therefore be more pronounced in 2021 than in 2019.

Although youth and social workers may recall episodes of communication about sexual health or facilitation of care differently, the accuracy of that number may not be as important as youth perceptions. Youth are unlikely to benefit from a conversation if they do not remember having it. Thus, youth reports may best represent the actual impact, rather than incidence, of SRH communication with social workers. Furthermore, this recall bias is less likely to affect youth recollections regarding facilitation of access to information or resources and perceived barriers or challenges than memories of conversations.

Second, the sensitive nature of the survey items may have induced some social desirability or reporting bias in youth responses to some items. This is consistent with the finding that 37% of youth reported feeling uncomfortable talking to adults about SRH. Such bias may be more likely in the 2019 (in-person) responses than in the 2021 (telephone) responses.

Finally, the language used in the survey questions may have been interpreted differently by youth and researchers. For example, in 2019, no participant reported that a social worker spoke to them about what a healthy relationship is; however, when asked what other topics a social worker had discussed, free-text responses included “being safe,” “being aware of domestic violence,” and “to be treated nicely,” which some people would define as indicators of healthy relationships.

Despite these limitations, this study provides valuable data that can contribute to policymakers’ and researchers’ understanding of SRH education and sexual development among Los Angeles youth in foster care. As California legislators and advocates for youth in foster care seek to monitor the impact of CFYSHEA in pursuit of better SRH outcomes among youth in foster care, this study offers insights into future research needs and strategies.

VII. Summary and Recommendations

CFYSHEA requires that social workers in California's child welfare systems inform youth about their rights to care and how to access that care, engage in age-appropriate and developmentally appropriate conversations on an annual basis, and facilitate access to care when youth request help to obtain care. To support social workers in fulfilling these responsibilities, the law also mandates that they undergo training in how to support the healthy sexual development of youth. This study assessed youth perspectives on their interactions with social workers and other sources of SRH information and services, key mechanisms for realizing the goals of CFYSHEA. In addition, the study examined whether youth's experiences varied with their age, race and ethnicity, gender identity, or sexual orientation. Key findings follow.

Many social workers address sexual and reproductive health development with youth, and more are beginning to do so.

Among youth who participated in the 2021 survey, 56% reported having had at least one conversation about SRH topics with a social worker in the past year. This marks a 10% increase over the 45% who reported doing so in 2019, suggesting that implementation of the new law may be having the intended effects. While just under half of youth reported that their social worker had discussed condoms (42.4%) or other birth control (41.5%) with them, only 17.5% reported having discussed how to know when they are ready to have sex, and no participant reported having talked with their social worker about unplanned pregnancy, their rights to confidentiality, or how to know if a relationship is healthy. This contrasts from the 2019 results, in which only 22.8% of youth said their social worker discussed birth control, though youth did report discussions on healthy relationships (23.4%), unplanned pregnancy (14.3%), and confidentiality (24.6%). The number of youth who reported that their social worker asked them if they had questions or wanted information about puberty, sex or SRH increased from 2019 (26%) to 2021 (35.8%). This result is notable in a year in which the COVID-19 pandemic locked down services and support for so many. Discussions about and facilitation of access to SRH care by social workers was much less common compared with more general conversations about information regarding these topics.

The percentage of youth who report these conversations, however, remains far below 100%. The pandemic may have delayed progress in implementing CFYSHEA: social workers, caregivers, and youth may have been occupied with other concerns, and the education of youth in care, as all K–12 education, was disrupted in many ways. Whatever the causes, California must make significant efforts to reach full implementation of CFYSHEA provisions.

Even though the law requires conversations to begin at age 10, younger youth are significantly less likely than older youth to report having conversations with their social worker about required topics.

In both 2019 and 2021, youth aged 12–16 were far less likely than older youth to report having had conversations on SRH topics. The reasons for these differences by age are unknown but may include social workers' varying perceptions of youth readiness and/or interest in discussing SRH topics and of priorities caring for youth. It also may suggest that social workers are uncomfortable discussing SRH development with younger youth or do not know age-appropriate conversation topics. These results suggest an opportunity to work with social workers to understand their perceptions and knowledge and provide support.

Differences among youth based on race and ethnicity, gender identity, and sexual orientation have implications for implementation and suggest opportunities for further research.

In addition to age differences, there were some differences among youth of different racial/ethnic backgrounds in both 2019 and 2021. In the 2021 multivariate analyses, which compared Latina or Latino youth with youth who identified as white or of other or multiple races or ethnicities, Latina or Latino youth were more likely to report that they obtained SRH information from friends, three times as likely to indicate that the pandemic had reduced their access to SRH education in school, and four times as likely to report that mental health issues posed a barrier to obtaining SRH services during the pandemic.

There is some evidence that male youth receive SRH information less often than female youth. In 2021, males' odds of having had conversations with their social workers about these topics were 80% lower than those of females. The 2021 findings echo findings from 2019 when male youth were less likely than female youth to report that they had received information on condoms, other birth control, STI treatment, or pregnancy from health care providers.

In 2021, youth who identified as having a sexual orientation other than heterosexual reported that not wanting their caregivers to know their sexual orientation was a barrier to obtaining SRH information or care. In 2019, the larger sample size allowed detection of many more differences between heterosexual and nonheterosexual youth: nonstraight or nonheterosexual youth were more likely than heterosexual youth to report that their social workers (a) provided them information about STIs and about how to access both STI treatment and prenatal care and (b) helped them access STI treatment. On the other hand, nonstraight or nonheterosexual youth were also more likely than heterosexual youth to say they had trouble accessing condoms, they were unable to see a health care provider with whom they were comfortable, that concern about someone finding out if they accessed SRH information or services was a barrier to obtaining information or services, and (as in 2021), that not wanting their caregiver to know their sexual orientation posed a barrier.

Further research into these differences may offer educators as well as health care providers, social workers, and caregivers guidance for preventing inequities among youth in access to information and services. Understanding differences among youth regarding the barriers they face may help those responsible for youth SRH development collaboratively create systems that meet the needs of all youth.

The COVID-19 pandemic affected access to social workers for a minority of youth and is likely not the cause of differences in reported CFYSHEA implementation among subgroups.

While the majority of youth (70.3%) said that the COVID-19 pandemic did not lessen their access to their social worker, the effects of the pandemic on youth access did appear to vary among certain groups. Youth ages 17–20 and those who identified as male or as nonstraight or nonheterosexual were more likely to report less access to their social workers. These differences are not consistent with differences in youth reports of SRH conversations with and support from social workers. For example, youth ages 17–20, who were more likely to report *less* access to social workers, were nevertheless *more* likely to report having SRH conversations and receiving support from social workers compared with younger youth. Reported conversations or support did not vary with youth sexual orientation. In addition, many of the differences in SRH support that youth reported in 2021 were also apparent in 2019, before the pandemic began.

The findings raise methodological questions and issues for continued research into sexual and reproductive health development and services among youth in foster care.

As noted above, this is the first study that has taken a quantitative approach to examining the experiences of youth in care vis a vis obtaining SRH information and services from social workers and other potential sources. Not surprisingly, some of the findings suggest that further research into measuring youth experiences related to SRH education and access to SRH information and services would be fruitful.

In some instances, the survey does not provide sufficient context to interpret the findings relative to standards of care. For example, California's Medicaid program, MediCal, has adopted the American Academy of Pediatrics guidelines for child and adolescent health care, Bright Futures (Hagan, Shaw, and Duncan, 2017).[3] For adolescents, these guidelines note that developmentally appropriate SRH care requires appointments that offer sufficient time and privacy for youth and health care providers to ask and answer each other's questions. The RHEP survey indicates that less than half of youth in care reported receiving SRH information from health care providers in the previous year: 41% in 2019 and 30% in 2021. In addition, in both years, about 10% of youth reported that accessing a health care provider with whom they felt comfortable posed a barrier to

[3] See https://brightfutures.aap.org/states-and-communities/Pages/California.aspx for information on how MediCal, California's Medicaid program, has implemented the Bright Futures guidelines.

obtaining SRH information or services. To evaluate these percentages vis a vis the AAP standards, researchers would need answers to such questions as what percentage of youth respondents saw health care providers in the last year? What percentage did so and were allowed private time with the health care provider? How much time? What percentage saw the same health care provider often enough to build the level of trust needed to feel comfortable speaking with the provider about SRH questions or concerns? Given the complexity of the topic, developing the optimal set of questions requires making trade-offs between the length of the survey (which affects response rates) and obtaining sufficient context to interpret the data usefully.

Measurement issues arise from question wording as well. For example, in 2019, no participant reported that a social worker spoke with them about what a healthy relationship is, but youth did indicate that social workers had spoken with them about "being safe," "being aware of domestic violence," and being "treated nicely." These findings raise the question of how youth understood the term "healthy relationships" if they did not think that whether one was safe, free of domestic violence, or being treated well were involved.

Other methodological research could address such questions as whether the age differences in youth reports of their conversations with social workers reflect social workers' behavior, age differences in understanding or remembering SRH conversations, or both. Younger youth could have a limited frame of reference for such conversations—the conversations may not be relevant to their current circumstances, making them less likely to learn from or remember them, for example. Without understanding the reason behind the finding, it would be more difficult to develop an effective mitigation strategy.

A number of strategies could address some of these measurement-related questions. Cognitive interviews, in which an interviewer asks potential respondents how they understand survey items, would allow researchers to clarify how youth of different ages and backgrounds interpret the term "healthy relationships," for example, and whether there are better ways for researchers to ask questions, so they know exactly what youth are telling them. Conducting cognitive interviews on intended survey items before collecting data allows researchers to calibrate their surveys so they know what they are measuring.

Another way to explore how and why youth's and social workers' perspectives on their interactions differ is for researchers to record or observe youth and social worker interactions and then later interview youth about those conversations. Alternatively, researchers could ask youth and social workers to report on what they discussed with each other at various intervals after they meet to learn whether there are discrepancies in their memories in the short and long terms. Must youth have multiple conversations, for example, before they begin to remember the discussions? Following such observational research, experimental studies testing strategies for engagement with youth on these topics could establish more effective ways for social workers, educators, health care providers, caregivers, and others to make the intended impact.

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Appendices

Appendix A: Full Survey

Great, I will now begin the survey. I will read the questions. I am required to read all of the answer options, but you can jump in with the answer. Please feel free to ask me clarifying questions if they come up. First, I am going to ask you a few quick questions about yourself. Please remember, you are allowed to *skip any question you'd rather not answer.*

Demographics

How old are you?
What language are you most comfortable speaking in?
What is your race and/or ethnicity? Choose all that apply
- African
- African-American or Black
- Arab or Middle Eastern
- Asian
- Latina or Latino
- Native American, American Indian, Alaskan Native, or Native Hawaiian
- Pacific Islander
- White or Caucasian
- Skip

What is your gender identity? Choose all that apply:
- Female
- Male
- Nonbinary, gender fluid, gender nonconforming, or gender queer
- Transgender female
- Transgender male
- Agender
- Skip

What is your sexual orientation? Choose all that apply:
- Asexual
- Bisexual
- Gay
- Straight (heterosexual)
- Lesbian
- Pansexual
- Queer
- Questioning or unsure
- Same-gender loving
- Prefer not to say

Conversations with social worker

Now we are going to talk about which specific topics you've talked about with your social worker. I am going to read a list of topics about sexual or reproductive health. Please say "yes" or "no" about if your social worker has talked with you about that topic in the past 1 year/12 months. If you are not sure if it was in the past 1 year, just try to estimate as best you can. Sound good?

In the past year has your social worker talked with you about
(Responses: Yes, No, I don't remember, Skip)

- Whether you have any questions or want any information about puberty, sex, or sexual and reproductive health.
- How to know if a relationship is healthy
- How to know when you are ready to have sex
- Birth control (other than condoms)
- Condoms
- Unplanned pregnancy
- STDs/STIs (sexually transmitted diseases and infections)
- How to handle pressure to have sex
- Your right to get SRH care when you want it
- Your right to confidentiality/privacy about your SRH care
- Your right to have questions answered and get information about these topics from a reliable source
- Abortion

Are there any other sexual health topics you can think of that they talked to you about?

Are there any relationship topics you can think of that they talked to you about?

In the past year, have you received information on birth control, condoms, STD treatment, or pregnancy care from any of the following? (Responses: yes/no)

- School
- Caregiver
- Friends
- Family (parents or relatives)
- Health care providers
- Other (such as mentor, coach, CASA)[4]

Access to health care

OK. We also want to know how youth in foster care get access to SRH services, such as places to get health care, STD testing, abortions, or birth control. I am going to read a list of resources and you can say "yes" or "no" if your social worker has talked to you about how to get each of these resources. This could mean they told you about locations, gave you pamphlets, or sent you links, things like that. Sound good?

In the past 1 year/12 months, has your social worker talked to you about how you or your partner can get access to these SRH care services or information?

- Birth control (other than condoms)
- Condoms
- STD/STI testing or treatment (STD/STI stands for "sexually transmitted diseases and infection")
- Information about choices and next steps when someone is pregnant
- Abortion

[4] Court appointed special advocate

Prenatal care
Where to get more information about any of the topics I just listed

Social worker help in accessing resources
Thank you. We will now ask you about whether your social worker has helped you get access to any resources. By "helped you get access," we mean things like helping you make appointments, arranging transportation, helping you work with insurance to get these, talking to your caregiver about getting access, etc.

This time, I will read a series of sentences as if I am you, and you will say "yes" or "no" about whether or not it's true for you.

My social worker has helped me get access to birth control (other than condoms) for me or my partner.
My social worker has helped me get access to condoms.
My social worker has helped me get access to STD testing or treatment.
My social worker has helped me get access to pregnancy care (pregnancy testing, prenatal care, abortion, birthing support).

OK. We'd also like to know if you have ever had trouble getting access to any of these resources. For each of the following resources please say "yes" if it has been difficult for you to get access to it.

Basic information about puberty, sex, or pregnancy
Birth control for me or a partner
Condoms
Testing or treatment for sexually transmitted infections or diseases (STIs or STDs)
Prenatal care or pregnancy testing
Abortion services
Information on healthy relationships

Barriers to accessing information and/or care
Finally, we would like to know more about what makes it hard for you to get health care or information about sex. I will read a list of reasons why it can be hard. Please say "yes" or "no" about whether or not this is a reason it's hard for you.

My caregiver/home/STRTP [short-term residential therapeutic program] refused to provide transportation to get resources or services
I was not able to go to a health care provider I feel comfortable with
I feel uncomfortable talking about sex and reproductive health care with adults
I was concerned about someone finding out
I don't have insurance or don't know how I would pay for it
My caregiver doesn't know my sexual orientation and I don't want to tell them
I didn't know who to ask for information or where to find information online
My group caregiver/home/STRTP wouldn't let me go
My group caregiver/home/STRTP doesn't allow people to have birth control

COVID-19 pandemic

In the past year, since the pandemic started, have you had more or less access to

your social worker/case worker?

(1 = a lot less, 2 = somewhat less, 3 = same, 4 = more, 5 = a lot more)

information on how to stay safe in your relationships?

(1 = a lot less, 2 = somewhat less, 3 = same, 4 = more, 5 = a lot more, 0 = I didn't want/try to access)

SRH services such as appointments to get contraception/birth control, STD testing, prenatal care, abortion services?

(1 = a lot less, 2 = somewhat less, 3 = same, 4 = more, 5 = a lot more, 0 = I didn't want/try to access)

sex ed through school, such as in a health, science, or other class?

(1 = a lot less, 2 = somewhat less, 3 = same, 4 = more, 5 = a lot more, 0 = I didn't want/try to access)

Finally in the past year, since the pandemic started, have any of the following made it *more difficult* for you to get access to SRH services? Please say "yes" if it made it more difficult for you to get access to it.

Finances/money
Housing/placement
Mental health
Education
Employment

Appendix B: Free-Text Responses

If youth reported talking to their social workers about topics other than those specified in the survey, they were asked what those topics were. Table B1 provides their responses grouped by youth age and gender identity.

Table B1

Free-Text Responses Regarding Other Sexual and Reproductive Topics Discussed With Social Workers

Age	Gender Identity	Response
16	Male	"Too young to take care of a child"

Youth who reported that they experienced barriers to a specific type of information or care were asked what the barriers were. Table B2 contains free-text responses, grouped by age and gender identity.

Table B2

Free-Text Responses Regarding Barriers to Specific Types of Care

Age	Gender Identity	Response
Why did the participant have trouble getting access to basic information?		
12	Female	"No one talked to me"
Why did the participant have trouble getting access to birth control?		
18	Female	"Partner"
Why did the participant have trouble getting access to condoms?		
14	Male	"I don't have money and don't want people to know"
15	Female	"They cost money"
Why did the participant have trouble getting access to prenatal care or pregnancy testing?		
17	Female	"Not being able to afford pregnancy test from the dollar store secretly"