Policy Options to Support the Sexual and Reproductive Health of Foster Youth in Washington State

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Abstract

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Youth in foster care experience disparate sexual and reproductive health outcomes relative to non-foster youth. Many factors influencing these disparities may be amenable to policy intervention. This analysis uses several strategies to critically examine policy options to support the sexual and reproductive health of foster youth in Washington state. First, it evaluates existing Washington law and policy related to the health of youth in foster care and finds the state has a responsibility to support the sexual and reproductive health of foster youth. Then, it analyzes policies in other states using critical review, direct evaluation of implemented programs, and interviews with policy experts. Next, it examines medical, public health, and legal literature to describe research- and expert opinion-informed policy recommendations. Finally, it synthesizes these analyses to provide specific policy recommendations for the state of Washington.

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Youth in foster care (YFC) are less likely than their non-foster peers to receive sexual and reproductive health (SRH) services across the reproductive life span, including sexual health education, family planning and abortion services, and prenatal care (Wallis, 2014). Compared to non-foster youth, YFC are more likely to experience sexually transmitted infections (STIs) (Ahrens et al., 2010; Courtney et al., 2005; Surratt & Kurtz, 2012), sexual violence (Finigan-Carr, Steward, & Watson, 2018; Polit, Morton, & White, 1989), and intimate partner violence (Courtney et al., 2011; Polit, et al., 1989). They also face numerous barriers to realizing their human rights to determine if and when to have children and to raise the children they have in safe, supportive environments (Wallis, 2014). The reasons for these disparate SRH outcomes among YFC are multifactorial and include system-, policy- and societal-level factors that may be amenable to policy intervention.

More than 10,000 children and adolescents in Washington state are in foster care (U.S. Department of Health and Human Services [HHS], 2018). The state of Washington does not require public schools to provide sexual health education (Washington State Department of Health, n.d.). Although Washington guarantees YFC the rights to "obtain or refuse reproductive health care, including birth control and/or counseling regarding birth control, without consent or knowledge of a parent or guardian" (Washington State Department of Social & Health Services [DSHS], 2015) and to access abortion without requiring the consent of a parent or guardian (RCW 9.02.100), logistic, cultural, and political barriers may prevent the realization of these rights among Washington YFC. To date, Washington has no state-wide policies specifically aimed at either ensuring YFC's SRH rights are maintained or supporting the SRH of foster youth.

This analysis explores policy options for supporting the SRH of foster youth in

Washington state. First, I outline the unique circumstances of YFC as they relate to health and healthcare. I then provide a definition of SRH and an overview of SRH outcomes for YFC. Next, I describe Washington state's foster care system, policies and procedures related to SRH services for YFC in Washington, and the state's responsibilities and interests vis-à-vis SRH for foster youth. Then, I present an analysis of existing state-level policies related to SRH for YFC in states other than Washington. Special attention will be given to the state of California, as it recently passed and implemented a state-wide policy aimed at improving the SRH of foster youth (the 2017 California Foster Youth Sexual Health Education Act). I then summarize the extant literature on recommendations for SRH policy for foster youth. Lastly, I synthesize these analyses to provide recommendations for state-level policies to support the SRH of foster youth in Washington state.

Background

The Foster Care System

Foster care "is a temporary service provided by states for children who cannot live with their families" (HHS, n.d.). Children and youth typically enter foster care in cases of confirmed or suspected abuse, maltreatment, or neglect. YFC may be placed in a variety of settings, including with relatives or unrelated foster caregivers (the latter, in particular, are often referred to as "foster parents") or in group homes, residential care facilities, or emergency shelters (HHS, n.d.).[1] The system aims to protect and provide for the health and safety of children while fostering reunification with their families or, when reunification is not possible, arranging

[1] Hereafter, the term "foster caregiver" is used broadly to refer to the adult(s) charged with caring for individual foster youth, including licensed foster parents, kinship caregivers (family members and non-related extended family members), and group home and residential facility staff.

alternative arrangements for permanent placement (Szilagyi, Rosen, Rubin, & Zlotnik, 2014). Responsibility for and legal authority over children and youth in the foster system may be shared between numerous actors, including the youth's biological parents, foster caregivers, and the state (Moore, 2012).

It is important to note the significant racial and ethnic disproportionalities and disparities present in the United States foster care system. Children of color, especially Black and American Indian/Alaska Native children, are overrepresented in the foster care system compared to their representation in general population (HHS, 2016). Historically, overrepresentation in the foster care system has been highest among Black children; in 1999, 42% of children in the United States foster care system were Black, compared to just 15% of children in the general population (Barbell & Freundlich, 2001). While the proportion of Black children in the foster care system decreased to 24% in 2014, Black children were still represented in foster care at a rate of 1.8 times their rate in the general population. American Indian/Alaska Native children were represented at a rate of 2.8 times their rate in the general population in 2014 (HHS, 2016). While Hispanic children are slightly underrepresented in the foster care system at the national level, they are overrepresented in 14 states (HHS, 2016). These disproportionalities result from disparate treatment of children and families of color across the foster care continuum. Hill (2006) summarizes racial and ethnic disparities in "reporting, investigation, substantiation, foster care placement, exit, treatment, services, [and] resources" (p. 3) for system-involved youth. In a 2011 review by the Center for the Study of Social Policy, Fluke, Harden, Jenkins, and Ruehrdanz found that four interrelated phenomena contribute to the disproportionality and disparities experienced by children of color in the foster care system:

> 1) disproportionate need resulting from differential risk due to the disproportionate number of children and families of color living in poverty;
> 2) racial bias and discrimination, which may be present at the individual level among child welfare staff and community reporters, as well as institutional racism[,] which may be inherent in the policies and practices of child welfare agencies;
> 3) child welfare system factors, including a lack of resources to adequately address the needs of children and families of color; and
> 4) geographical context, including neighborhood effects such as concentrated poverty on maltreatment rates, and other community contextual factors that may contribute to differential rates of maltreatment or placement outcomes (as cited in Dettlaff, 2015, p. 5).

Trauma, adversity, and toxic stress are near-universal among YFC (Szilagyi et al., 2014). Many YFC have limited access to healthcare services and experience unmet healthcare needs (Szilagyi et al., 2014). Untreated medical problems, chronic medical conditions, oral health needs, mental health disorders, and behavioral and developmental disorders are common among youth entering foster care (Szilagyi et al., 2014). Trauma, poor access to healthcare, and untreated and/or chronic medical problems may have profound effects on SRH outcomes among foster youth (Ahrens, Spencer, Bonnar, Coatney, & Hall, 2016; Billings, Harshem, & Macvarish, 2007).

Defining "Sexual and Reproductive Health"

Sexual health – particularly for adolescents and young adults – is often defined in negative terms: "as the absence of infections such as chlamydia, gonorrhea, and HIV, as the

avoidance of pregnancy among teenagers, and as the avoidance of sexual violence and abuse" (Aggleton and Campbell, 2000, p. 284). However, as the National Commission on Adolescent Sexual Health notes, "adolescent sexual health is defined by a broad range of knowledge, attitudes, and behaviors and cannot be defined solely on the basis of abstinence or preventive behaviors" (Haffner, 1995, p. 2). Aggleton and Campbell provide a positive and affirming definition of sexual health, using a human rights framework, with four key tenets:

> sexual health is (or should be) an affirmative concept, a state of well-being imbued with positive qualities, not merely the absence of those that are undesired. Thus sexual health is about a lot more than the avoidance of STIs and unwanted pregnancy, although these may be preconditions for its attainment. Second, sexual health is more than reproductive health, being concerned with more than procreative relationships and modes of sexual expression. Third, sexual health seems inextricably linked to the expression of individual and collective needs as well as to broader human rights and responsibilities. The concepts of sexual health which seem most valid are those which respect the variety and uniqueness of sexual experiences, needs and identities. They are those, moreover, which affirm the right of all people to be free from sexual exploitation[,] oppression[,] and abuse. Sexual health, therefore, is not simply an individual state of being. Finally, sexual health must be concerned with the attainment and expression of sexual pleasure, not with the repression of sexual energies and desires or their denial (p. 285).

As Aggleton and Campbell state, sexual health is distinct from but closely related to reproductive health. Like sexual health, reproductive health is often defined in negative terms as

the absence of "disease, dysfunction, or infirmity" of the reproductive system (United Nations, 2002). An affirming view – shared by the international medical, human rights, and development communities – defines reproductive health as "a state of complete physical, mental, and social well-being" related to "the reproductive processes, functions[,] and system at all stages of life" (United Nations, 2002). Reproductive health care, therefore, must include a full spectrum of services – including human papilloma virus vaccination, screening for and treatment of reproductive tract cancers, services related to sexual and gender-based violence, HIV pre-exposure prophylaxis, safe abortion services, infertility treatment, and prenatal, childbirth, and postpartum care – not just STI treatment and contraception. Furthermore, integral to this definition of reproductive health is that all people "have the capability to reproduce and the freedom to decide if, when[,] and how often to do so" (United Nations, 2002).

Achieving SRH as defined above requires the realization of sexual and reproductive human rights, including the rights to

- have [one's] bodily integrity, privacy, and personal autonomy respected;
- freely define [one's] own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose [one's] sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;

- have access over [the] lifetime to the information, resources, services, and support necessary to achieve all of the above, free from discrimination, coercion, exploitation, and violence (Starrs et al, 2018, p. 2646).

SRH is also inextricably linked with overall health and well-being. SRH is fundamental to general health, and, likewise, one's SRH status may be affected by his or her general health. Moreover, an individual's SRH may "reflect [his or her] health during childhood,… [affects overall] health beyond the reproductive years for both men and women, and affects the health of the next generation" (United Nations, 2002). Thus, general concepts of "health" and "health care" must incorporate SRH and services, respectively.

A comprehensive, integrated definition of SRH therefore views both sexual and reproductive health in positive, affirming terms; focuses on well-being rather than the absence of disease; includes a wide range of services to meet the needs of individuals across the reproductive lifespan; and requires the realization of fundamental human rights related to sexuality and reproduction as well as rights related to general health and well-being. This definition forms the foundation of the analysis of and recommendations regarding SRH for foster youth provided hereafter. Throughout this analysis, "sexual and reproductive health" should be understood to refer to the conditions described above rather than simply the absence of STIs and/or pregnancy.

Sexual and Reproductive Health Among Youth in Foster Care

Most of the literature on SRH among YFC focuses on negative outcomes, including STIs and unwanted pregnancy. Several studies have demonstrated increased rates of STIs and

unwanted pregnancies among YFC relative to non-system involved youth. In one study of over 14,000 adolescents and young adults, former foster youth were significantly more likely than their non-foster peers to be actively infected with gonorrhea, chlamydia, and trichomonas, with odds ratios for infection ranging from 2 to 14 (Ahrens et al., 2010). Although data on HIV in the foster population is limited, Surrat and Kurtz (2012) found that a history of foster care was associated with an increased risk of HIV infection among high-risk adults. Additionally, approximately half of young women in foster care report being pregnant at least once by age 19, compared to 20% of non-foster involved young women (Courtney et al., 2005); importantly, a significant proportion of YFC report their pregnancies were unwanted (Courtney et al., 2016).

As Young (2010) notes, STIs and child bearing among YFC "receive a great deal of attention" (p. 1) because of the social stigma associated with and economic costs often attributed to them; however, as noted above, SRH is not defined by STIs or pregnancy alone. Other aspects of YFC's SRH – such as personal safety, psychological well-being, the presence of supportive relationships, sexual satisfaction, and access to a full range of sexual and reproductive healthcare services – are less well studied. Limited studies in the foster population suggest high rates of intimate partner violence (Finigan-Carr et al., 2018) and forced sex (Finigan-Carr et al., 2018; Polit et al., 1989). Additionally, a 2009 study of pregnant and parenting YFC found nearly one quarter (22%) did not receive care prenatal until the third trimester or received no prenatal care at all (Dworsky & DeCoursey, 2009).

The literature overwhelmingly attributes poor SRH outcomes among YFC to youth's individual behaviors, often without consideration of the influence of the context in which these behaviors occur or acknowledgement of the complex social and structural factors that limit YFC's choices. For example, YFC are often noted to have an earlier age at sexual debut, to have

more sexual partners, and to use condoms and other contraception less frequently than their non-system involved peers (Finigan-Carr et al., 2018; James, Montgomery, Leslie, & Zhang, 2009; Leslie et al., 2010; Polit et al., 1989). Examination of the structural and systems-level factors that influence these behaviors and contribute to disparate SRH outcomes among YFC suggests several that may be amenable to policy intervention, including inadequate sexual health education and limited access to SRH services.

Foster youth face numerous barriers to sexual health education. YFC may have limited access to school-based sex education, even where such education is mandated by law, as a result of frequent changes in foster placement and associated changes in school placement (Constantine, Jerman, & Constantine, 2009; Wallis, 2014; Young, 2010). In many states, foster caregivers may deny YFC permission to attend school-based sex education for religious or cultural reasons, even if the youth does not share the caregiver's religious or cultural beliefs (Constantine et al., 2009; Robertson, 2013). Additionally, foster youth often do not have access to more informal sex education from parents and other family members, as foster caregivers report feeling unprepared or unqualified to provide YFC with information about SRH; likewise, YFC report discomfort with and fear of talking to foster caregivers about sex (Constantine et al., 2009; Love, McIntosh, Rosst, & Tertzakian, 2005; Robertson, 2013; Wallis, 2014). Furthermore, child welfare agencies, often tasked with providing health and human services to YFC, do not consistently provide sex education for foster youth for a variety of reasons, including budget and personnel limitations as well as cultural, religious, political, and legal concerns (Love et al., 2005; Robertson, 2013; Wallis, 2014). Child welfare professionals describe a lack of training, discomfort with the topic, and conflicting personal beliefs as barriers to discussing sexual and reproductive health with youth in their care (Bruce, 2016; Constantine, et al., 2009; Love et al.,

2005). Foster youth who do receive sex education frequently describe this education as "too little, too late" or otherwise inappropriate for their circumstances and needs (Ahrens et al., 2016; Love et al., 2005). Foster youth consistently report a need for more communication with trusted adults, including foster caregivers, about sex (Bruce, 2016; Constantine et al., 2009).

In addition to these barriers to sex education, YFC face numerous barriers to accessing SRH care. Although YFC are categorically eligible for Medicaid, and over 99% of YFC have health insurance (Raghavan, Aaron, Roesch, & Leslie, 2008), foster youth may experience fragmented medical care as a result of changing placements and may not know how or where to seek SRH services (Young, 2010). Additionally, although YFC have the same SRH rights as their non-foster peers (Robertson, 2013), youth, along with their caregivers and caseworkers, may be unaware of foster youth's rights regarding consent and confidentiality (Young, 2010). As a result, YFC may avoid SRH services because of concerns about confidentiality; furthermore, misinformed caregivers and caseworkers may unintentionally discourage foster youth from seeking SRH services by providing false information about YFC's rights (Young, 2010). Moreover, caregivers – and the state itself – may intentionally deny YFC their rights to SRH services; notable cases include that of a California foster group home that confiscated YFC's condoms and contraceptives and the state of Nebraska's decision to deny a pregnant foster youth access to abortion (Juneja, 2016; Wallis, 2014).

The SRH of foster youth in the United States is also shaped by the country's longstanding history of stratified reproduction, in which the fertility, childbearing, and parenting of some – including poor people, people of color, young people, people with disabilities, people with mental illness, and those involved with the child welfare and criminal justice systems – is systematically devalued, and by the reproductive injustices experienced by these groups

(Gubrium et al., 2016; Harris & Wolfe, 2014). Such injustices are often mediated by policies – including state and federal laws, public health initiatives, and social service programs – implicitly or explicitly aimed at preventing reproduction among particular groups; examples include the forced or coerced sterilization of women of color and incarcerated women; requirements or financial incentives for women receiving public benefits to use contraception; limiting or eliminating public benefits for families who have additional children while receiving benefits; mandating the use of long-acting contraception as part of criminal sentencing; mandating contraception for women with substance use disorders; and Medicaid policies that freely fund the insertion of long-acting contraceptives but restrict funding for removal (Arnow, 1996; Gold, 2014; Gomez, Fuentes, & Allina, 2014). More subtly, policies and programs designed to promote long-acting reversible contraceptives (LARC) among "high-risk" populations – namely, those listed above – may restrict the reproductive agency of these persons (Gold, 2014; Gomez et al., 2014). As a result of this reproductive stratification, in which reproduction among YFC is viewed as undesirable, interventions related to SRH for foster youth largely focus solely on preventing pregnancy rather than on supporting youth's overall SRH.

In sum, as Young notes, "across the reproductive spectrum, the state fails to provide foster youth with the resources, rights, and support necessary" to make decisions about their SRH and achieve their reproductive health-related goals (2014, p. 121). As described above, many of the barriers to optimal SRH faced by YFC may be amenable to policy intervention. This analysis seeks to examine the foster care system and related laws, policies, and structures in Washington state and to provide recommendations, informed by critical analysis of existing literature, expert opinion, and evaluation of novel programming, for state-level policies to support the SRH of foster youth in Washington.

Review of Relevant Policy in Washington State

As noted above, Washington is home to more than 10,000 children and youth in foster care (HHS, 2018). As of 2017, the Washington State Department of Children, Youth, and Families (DCYF) oversees the state's foster care system. DCYF is a cabinet-level agency; its secretary is appointed by the governor (RCW § 43.216.015). DCYF was established in 2017 and consists of several entities previously housed in the Department of Early Learning and the Department of Social and Health Services (DSHS), including the Children's Administration and Child Protective Services. Prior to the creation of DCYF, the foster system was administered by DSHS (RCW § 43.216).

Washington statutes and legislation related to the health of foster youth as well as relevant DCYF practices and procedures are outlined below. Additionally, because many of these statutes and policies were influenced by *Braam v. State of Washington*, the case is briefly described below. Notably, Washington has no laws or policies specifically aimed at ensuring YFC's SRH rights are maintained or supporting the SRH of foster youth.

Braam v. State of Washington

In 1998, 13 foster children sued the state of Washington, alleging the state's practice of frequently moving foster youth between multiple placements caused emotional and psychological harm and violated YFC's constitutional rights (Martyna, n.d.). The class action lawsuit eventually grew to include more than 3,000 Washington foster youth as plaintiffs (Martyna, n.d.). The case was settled in 2004.

The hallmark of the initial Braam settlement agreement was the creation of an independent oversight panel comprised of five national experts in child welfare (Washington

State Department of Children, Youth, and Families [DCYF], n.d.). The panel was tasked with monitoring the state's compliance with the Braam settlement agreement and issuing public monitoring reports every six months (Columbia Legal Services, 2018). In 2006, the panel published an Implementation Plan outlining target outcomes and benchmarks as well as required action steps for the state in order to improve the experiences of foster youth and meet the requirements of the Braam settlement agreement. The Implementation Plan was revised in 2008. Additionally, in 2008, the Braam plaintiffs filed a motion stating the state was noncompliant with the settlement agreement and requesting court enforcement of four specific areas of the Implementation Plan. The Superior Court of Whatcom County ruled the state was noncompliant with the settlement agreement and Implementation Plan and ordered the state "to demonstrate substantial improvement toward compliance within 90 days;" however, "the state failed to come into compliance for several years" (Columbia Legal Services, 2018). The initial settlement agreement expired in 2011; however, given the state's failure to meet several of the required outcomes, the parties negotiated a Revised Settlement and Exit Agreement, which extended the settlement until December 2013. While the state continued to make progress after the adoption of the Revised Settlement and Exit Agreement, it failed to achieve full compliance with all 21 outcomes by December 2013 as required. In 2014, the Superior Court of Whatcom County ruled the state must fulfill the requirements of the Revised Settlement and Exit Agreement regardless of the expiration date. The oversight panel was disbanded in 2013; the state continues to report progress biannually to the Court and the plaintiffs' counsel (DCYF, n.d.). As of December 2016, the state remains noncompliant with two of the 21 required outcomes outlined in the Revised Settlement and Exit Agreement (DCYF, n.d.).

The Braam settlement required a number of changes to medical care for YFC provided by

DSHS (now DCYF). Included in the terms are requirements for DCYF to provide YFC with (1) initial health screenings within five days of placement, (2) comprehensive physical and mental health screenings within 30 days of placement, (3) a comprehensive health and education plan, and (4) regular and periodic updates to screenings and assessments as described below (DSHS, 2007). Statues, policies, and practices pursuant to these requirements are described below. Neither the original Braam settlement nor any of its revisions specify that comprehensive health services must include SRH care.

Summary of Relevant Washington Law

The Revised Code of Washington (RCW) and Washington Administrative Code (WAC) codify state law related to foster youth and their caregivers. Most relevant statutes are found in RCW Title 74 ("Public assistance"), Chapters 13 ("Child welfare services") and 14A and B ("Children and family services," "Children's services"). Administrative code regulating DCYF is found in Title 110 ("Department of Children, Youth, and Families"), Chapter 50 ("Child welfare"). Laws relevant to SRH for foster youth are outlined in **Table 1**.

RCW § 74.13.031 requires DCYF to "care" for youth in the foster system and authorizes the department "to provide for the routine and necessary medical" care of foster youth. Additionally, Title 74 requires the state to "address the educational, physical, and medical needs of children and youth in need of long-term care, including those in foster care for two years or more and those with multiple foster placements." Pursuant to this requirement, Title 74 also requires DCYF to evaluate the long-term educational, physical, and medical needs of all children entering the foster system within 30 days of placement.

In general, Washington law allows minors of any age to consent to birth control,

abortion, and prenatal services without parental consent or notification ("Providing health care to minors under Washington law," 2006). Minors 14 years of age and older have the right to consent to testing and treatment for STIs (RCW § 70.24.110). Neither the RCW nor the WAC codifies a comprehensive list of rights for YFC. However, the RCW does include two statues describing the rights of foster caregivers (RCW §§ 74.13.332 & 74.13.333). In DSHS publications aimed at YFC, including "Your Rights, Your Life: A Resources for Youth in Foster Care" and the "Rights of Children and Youth in Foster Care" declaration form (**Appendix B**), the state affirms that foster youth have the same rights as other youth to "obtain or refuse reproductive health care, including birth control and/or counseling regarding birth control, without consent or knowledge of a parent or guardian" at any age and to "obtain tests and treatment for sexually transmitted infections without consent of a parent or guardian" if 14 years of age or older (DSHS, 2015; DSHS, 2016); however, the state does not explicitly affirm that YFC have the right to access abortion without the consent of a parent or guardian (a legal right protected for all women in Washington by RCW § 9.02.100), instead stating YFC have the right to "know Children's Administration's duties and responsibilities if [they are] pregnant or a parenting foster youth and that [their] needs will be addressed and services will be provided" (DSHS, 2015).

Washington does not require its public schools to provide sexual health education (Washington State Department of Health, n.d.), nor does it mandate or offer sexual health education for YFC. Although RCW § 74.13.250 requires foster caregivers to undergo training prior to assuming care of a youth, the law does not require this training to include information on SRH.

Summary of Relevant DCYF Practices and Procedures

DCYF Practices and Procedures operationalize state laws and other policies, such as the Braam settlement requirements, related to the Washington child welfare system. DCYF Practices and Procedures relevant to SRH for foster youth are summarized in **Table 2**.

DCYF 4517 mandates that all YFC receive a health screening examination by a medical provider within five calendar days of entering the foster system. The initial health screen is intended to identify and address any urgent medical needs present at the time of placement; it includes assessment of the youth's medical history, immunization status, and medications as well as a comprehensive physical exam, including growth parameters, vital signs, and evaluation for bruises, scars, and/or other signs of physical abuse. Medical providers are responsible for documenting their findings along with recommendations for a plan of care, follow up, and any necessary referrals. DCYF caseworkers are responsible for ensuring YFC receive an initial health screening, communicating any results and/or recommendations from the health screening to the youth's caregiver, and verifying that youth receive any follow-up care recommended by the screening provider.

Pursuant to RCW § 74.14A.050, DCYF 43092 requires that youth who are expected to remain in foster care for 30 days or more receive a comprehensive, in-person evaluation through the Child Health and Education Tracking (CHET) program. CHET is intended to organize information about YFC's well-being and to identify their physical health and educational needs (DSHS, 2006a; DSHS, 2006b). CHET screening assesses five domains (physical health; development; education; emotional/behavioral health; and connections to family, community, and peers) and is performed by a dedicated CHET social worker using standardized screening instruments. Physical health screening is performed using the Medicaid Early and Periodic

Screening, Diagnosis, and Treatment (EPSDT) well-child examination form (DSHS 2006a). The CHET program outlines specific criteria for children with complex or unmet medical needs to be referred to a Foster Care Public Health Nurse for further evaluation (DSHS, 2006b). After completion of the initial screening, CHET social workers are required to document their findings and share the written report with the youth's foster caregiver(s) and social worker(s) at a shared planning meeting (DSHS, 2006a; DSHS, 2006b). At the initial shared planning meeting, screening results are used to develop a plan to meet the youth's needs; subsequent shared planning meetings may occur as needed to review the youth's case plan and support their ongoing needs (DSHS, 2006a).

DCYF also mandates ongoing well-child care for foster youth. DCYF 4517 requires Department caseworkers to ensure YFC receive EPSDT examinations annually until age 20, to provide youth with EPSDT results, and to assist youth in obtaining any recommended additional healthcare services.

DCYF 43102 requires Department caseworkers to provide YFC with written information about their rights annually starting at age 12; it also requires YFC to sign the "Rights of Children and Youth in Foster Care" declaration form (**Appendix B**) acknowledging they have received information about their rights in a way they can understand. As noted above, these documents affirm YFC's rights to obtain reproductive health care, including contraception at any age and testing and treatment for STIs at age 14 or older, without the knowledge or consent of a guardian, but they do not affirm youths' right to obtain an abortion without the knowledge or consent of a guardian at any age, nor do they state that YFC have the right to the full spectrum of age-appropriate SRH care services. In addition to affirming YFC's right to seek services related to STIs, DCYF specifies in DCYF 4520 that the Department must provide foster youth who are

HIV positive or at risk for HIV with appropriate services, including coordination, information, and referral services.

Foster Care Health Unit (Substitute House Bill 2985)

In 2006, Washington enacted Substitute House Bill 2985, creating a Foster Care Health Unit in DSHS. The Unit was created to evaluate the existing healthcare system for YFC and to provide recommendations to the Washington State Legislature to improve the "structure, organization, and coordination of health care available to children in foster care" (DSHS, 2006b, p. 3). The Unit found FYC "have difficulty accessing the health and mental health services that they need" (DSHS, 2006b, p. 4) and recommended action steps to improve access to YFC's medical information for DSHS staff, foster caregivers, and medical providers; to improve health care coordination for YFC; and to improve mental health care coordination for YFC (DSHS, 2006b). The Unit also recommended the creation of a permanent Office of Foster Care Health within DSHS to address the healthcare needs of YFC; however, a permanent Office was not formed, and the Foster Care Health Unit expired on January 1, 2007 (DSHS, 2006b).

Assessment of Washington's Responsibilities and Interests vis-à-vis Sexual and Reproductive Health for Foster Youth

Washington has a legal responsibility, established through both legislation and the Braam settlement, to provide YFC with routine and necessary medical care (DSHS, 2007; RCW § 74.13.031). As noted above, sexual and reproductive health are fundamental to general health and overall well-being (Starrs et al., 2018; United Nations, 2002), and thus the state's responsibility to provide routine and necessary medical care for YFC includes a responsibility to

address youth's SRH needs. Furthermore, Washington has a legal responsibility to identify and effectively address the long-term health needs of youth in care (RCW § 74.14A.050). Because, as the UN (2002) notes, reproductive health "sets the stage for health beyond the reproductive years for both women and men and affects the health of the next generation," in order to effectively address the long-term health needs of its YFC, the state must support their SRH.

Washington also has a responsibility to provide services and supports in response to what YFC say they need, and to "meet those needs in a way that maintains their dignity and respects their choices" (RCW § 74.14A.050). Thus in addition to having a legal obligation to provide YFC with medical care related to SRH, the state has a duty to provide youth with additional supports and services, such as education, counseling, and parenting support, to meet their SRH needs.

Review of Relevant Policy in Other States

Like Washington, most states have laws and/or state departmental policies mandating general health care for foster youth (Risley-Curitss & Kronenfeld, 2001). Additionally, many states have passed Foster Youth Bill of Rights laws, which may include rights to SRH education and services (National Conference on State Legislatures, 2016). However, little is known about specific state laws and policies related to SRH for YFC. To date, only two studies are known to have examined state-level SRH policies for foster youth. In 1987, Polit, White, and Morton surveyed representatives from child welfare agencies in 48 states and found only nine states had written policies related to SRH for YFC. The authors note that of these nine states, most had only "a brief statement in their social services handbook indicating what a caseworker can or cannot do in certain circumstances" (Polit et al., 1987, p. 20). Only two of these states had

"comprehensive policies designed to meet the sexual development needs of the child-welfare population" (Polit et al., 1987, p. 20). Polit et al. also found that while 29 states offered or recommended training in SRH for foster caregivers, only five of these states required such training; additionally, SRH training for child welfare caseworkers was offered or recommended in 19 states and required in only four. No states collected information on SRH outcomes for YFC.

In 1996, the Child Welfare League of America surveyed child welfare agencies in all 50 states and the District of Columbia. Only ten states reported having written policies related to sexual health education and/or family planning services for YFC (Mayden, 1996). Notably, only one of the nine states which reported having a SRH policy in Polit et al.'s 1987 study (Texas) still had a formal SRH policy at the time of the Child Welfare League's study. The Child Welfare League's survey also found that SRH training was offered for foster caregivers and child welfare caseworkers in only 11 and 17 states, respectively. The authors did not specify whether such training was mandatory in any of these states. Of note is that neither Polit et al. nor Mayden evaluated the implementation of SRH policies in states where formal policies were present. Whether these policies were implemented as written is unknown; furthermore, whether the policies had any effect on SRH outcomes among YFC is also unknown.

Literature and web searches conducted as part of this analysis revealed evidence of SRH policies for foster youth in only two states – New York and California. New York state law requires local departments of social services to offer family planning services to YFC (N.Y. Comp. Codes R. & Regs. tit. 18, § 463.1) and to provide or arrange for such services within 30 days of youth requesting them (N.Y. Comp. Codes R. & Regs. tit. 18, §§ 463 & 507.1). New York law also requires local departments of social services to inform foster caregivers in writing

about the availability of family planning services for YFC within 30 days of placement (N.Y. Comp. Codes R. & Regs. tit. 18, § 441.22). Both the New York State Office of Children & Family Services and the New York City Administration for Children's Services have published administrative directives requiring child welfare agencies to provide YFC with sexual health education and with a wide range of reproductive health services, including contraception, emergency contraception, pregnancy testing and counseling, abortion, STI testing and treatment, HIV testing and care, human papilloma virus vaccination, and prenatal and postpartum care (Aladin, 2013; New York City Administration for Children's Services, 2014; New York State Office of Children & Family Services, 2011). Administrative directives also affirm YFC's rights to consent to SRH care and to receive confidential SRH services. As with other states, the extent to which local departments of social services in New York have implemented these mandates is unknown.

The policies and experiences of California are of particular interest to this analysis, as the state has passed several laws related to SRH for YFC. Notably, California recently passed the California Foster Youth Sexual Health Education Act, a broad policy aimed at improving SRH for foster youth. This law, along with its historical context and other relevant California policy, is examined in detail below.

The Context and History and of Sexual and Reproductive Health Policy for Foster Youth in California

California has the largest foster population of any US state (HHS, 2018). In 2018, nearly 60,000 children and youth in California were in foster care (California Child Welfare Indicators Project, n.d.). Foster care in California is a "state supervised, county administered system"

overseen by the California Department of Social Services (CDSS) and administered by 58 county child welfare agencies (Youth Law Center, 2016, p. 1). California law related to the foster care system is primarily codified in the California Welfare and Institutions Code.

California has enacted several laws directly related to SRH for YFC; a number of other laws indirectly affect SRH policy for foster youth. In 1996, the California State Assembly passed Assembly Bill (AB) 1127, codified as CAL Welf. & Inst. § 16521.5. AB 1127 required foster caregivers (or county case managers, if caregivers object) to provide adolescents in foster care with age-appropriate information on pregnancy prevention, to the extent county and state resources are provided. AB 1127 stipulated this requirement would not take effect until a work group, created by CDSS and the Department of Health Services (now the California Department of Health Care Services), developed a pregnancy prevention plan describing caregivers' and case managers' specific duties and responsibilities. The Bill identified specific organizations and roles to be represented in the work group. It also outlined several requirements for the work group's pregnancy prevention plan, including delineation of the role of foster caregivers and case managers, strategies to involve foster youth peers, the identification and provision of appropriate educational materials, and training for caregivers and case managers. Finally, AB 1127 directed CDSS to adopt regulations to implement the law's provisions. While a work group was convened, the mandate was never funded, and the bill's provisions were not enacted until 2016 (Bruce, 2016; California Department of Social Services [CDSS], 2016; Constantine et al., 2009).

In 2001, the California State Legislature passed Assembly Bill 899, establishing a Foster Youth Bill of Rights (see **Appendix C**). The bill codified a centralized list of rights guaranteed to all children and youth in foster care in CAL Welf. & Inst. § 16001.9. It also requires social workers to inform YFC of their rights in an age-appropriate manner at least once every six

months (CAL Welf. & Inst. § 16501.1) and requires facilities that care for six or more foster youth to post the list of rights publicly (CAL Welf. & Inst. § 1530.91). In 2016, the Legislature passed Assembly Bill 1067, intended to strengthen and expand the Foster Youth Bill of Rights. AB 1067 mandated the creation of a working group of stakeholders, to include current and former foster youth, to provide the Legislature with recommendations for revising the Foster Youth Bill of Rights, disseminating the revised information to YFC, and measuring and improving YFC's access to information about their rights (CAL Welf. & Inst. § 16001.8).

In 2009, Constantine et al. conducted a foster youth "sex education and reproductive health needs assessment" (p. 7) in three California counties. The assessment used interviews, focus groups, and surveys of child welfare professionals, foster caregivers, and former foster youth to identify the unique sexual and reproductive health needs of foster and transitioning youth as well as barriers to addressing these needs and recommended strategies for addressing these barriers. The assessment found "unclear policies, unclear roles, and liability" (p. 21) were barriers to addressing the sexual and reproductive health needs to YFC. Specifically, child welfare professionals and foster caregivers reported confusion as to their roles related to sex education and reproductive health for YFC, citing an absence of clear policies or procedures. Additionally, participants described a lack of clear policies on liability, parental rights, and confidentiality as a barrier to addressing youth's SRH needs. Participants reported receiving inadequate training in adolescent sexuality and described feeling unprepared to have conversations about SRH with foster youth; they strongly recommended child welfare agencies implement ongoing formal SRH training for all staff.

In 2012, Bruce (2013; 2016) performed a mixed-methods study of policies and procedures related to SRH for YFC in 18 California counties. Only two of the 18 counties had

formal policies related to SRH for foster youth. Child welfare professionals reported a lack of clearly defined expectations, guidance, or procedures related to SRH for YFC and described their delivery of sexual health information, resources, and services as varied and occurring on a case-by-case basis. As in the Constantine et al. study, child welfare professionals described an absence of clear policies and procedures as a barrier to supporting the SRH of YFC; they also reported a need for more training in adolescent sexuality and family planning. Participants recommended implementing formal county-level policies clearly describing professionals' roles and responsibilities related to SRH for foster youth, specific sexual and reproductive health topics that should be discussed in their work, and regulations related to privacy, confidentiality, and consent.

In 2013, California enacted Senate Bill 528. The bill was informed by a variety of experts in child welfare and endorsed by numerous advocacy, legal, heath, and public health organizations. The law (a) specifies that YFC have the right "to consent to, among other things, the diagnosis and treatment of sexual assault, medical care relating to the prevention or treatment of pregnancy, including contraception, abortion, and prenatal care, [and] treatment of infectious, contagious, or communicable diseases;" (b) authorizes social workers to inform YFC aged 12 years and older of their right to consent to the services listed above; (c) authorizes social workers to provide YFC with age-appropriate, medically accurate information about sexual development and reproductive health, including information about preventing pregnancy and STIs, on an ongoing basis (CAL Welf. & Inst. Code § 369); and (d) added the right "to have access to age-appropriate, medically accurate information about reproductive health care, the prevention of unplanned pregnancy, and the prevention and treatment of STIs at 12 years of age or older" to the Foster Youth Bill of Rights (CAL Welf. & Inst. Code § 16001.9). The law also amended the

Foster Youth Bill of Rights to specify the rights apply to "all minors and nonminors in foster care" rather than "foster children" (CAL Welf. & Inst. Code § 16001.9).

Senate Bill 528 also bolstered support for pregnant and parenting foster youth. The bill requires parenting YFC and their children to be provided, "to the greatest extent possible," access to support services and resources, including but not limited to "child care, parenting classes, and child development classes" (CAL Welf. & Inst. Code § 16002.5). The law contains several provisions aimed to expand pregnant and parenting YFC's access to child care, including declaring them eligible for federal- and state-subsidized child care, giving the children of YFC priority in subsidized child care placement, and requiring child welfare agencies and educational agencies to "make reasonable and coordinated efforts to ensure that minor parents and nonminor dependent parents who have not completed high school have access to school programs that provide onsite or coordinated child care" (CAL Welf. & Inst. Code § 16002.5). The law also authorizes child welfare agencies to provide pregnant and parenting YFC with access to social workers or resource specialists with special training on the needs of young parents and requires the state to offer pregnant YFC a specialized conference to assist them in planning for healthy parenting. Additionally, the law expanded the existing legal requirement for minor parents "to be given the ability to attend school, complete homework, and participate in age and developmentally appropriate activities separate from parenting" to include nonminor parenting foster youth (CAL Welf. & Inst. Code § 16002.5). Finally, the law requires counties to collect data on pregnant and parenting YFC on an ongoing basis.

In 2016, pursuant to AB 1127 and CAL Welf. & Inst. § 16521.5, CDSS formed the Healthy Sexual Development Workgroup. The Workgroup consists of stakeholders from a number of state agencies as well as independent organizations and aims to address the SRH

needs of YFC (CDSS, 2016b). In September 2016, the Workgroup issued All County Letter (ACL)[2] 16-82, addressed to child welfare and other related agencies, outlining YFC's SRH rights (CDSS, 2016a). The letter served to inform relevant agencies of YFC's legal SRH rights and as a mandate to these agencies to fulfil any applicable legal responsibilities related to SRH for YFC. The Healthy Sexual Development Workgroup also developed a pregnancy prevention plan as required by AB 1127 and distributed the plan to county child welfare agencies in October 2018 via ACL 16-88 (CDSS, 2016b). In addition, the Workgroup developed a youth-facing educational website about SRH for YFC (CDSS, 2018a).

In 2016, California also enacted the California Healthy Youth Act (CHYA), mandating comprehensive sexual health and HIV/AIDS education for all students (CAL Educ. Code §§ 51930–51939). CHYA aims to (a) equip students with knowledge and skills needed to prevent STIs and unwanted pregnancy, (b) promote healthy attitudes around "body image, gender, sexual orientation, [and] relationships;" (c) promote sexuality as a normal part of development; (d) provide accurate, unbiased, comprehensive sexual health education; and (e) empower students with the knowledge and skills needed to establish "healthy, positive, and safe relationships and behaviors." The law requires public schools to provide age-appropriate, medically accurate, comprehensive sexual health education and to ensure students receive this education at least once in middle school and once in high school (CAL Educ. Code § 51934). The law also requires sexual health education to be "affirming of different sexual orientations" as well as "inclusive of same-sex relationships" and to teach about "gender, gender expression, gender identity, and… the harm of gender stereotypes" (CAL Educ. Code § 51933). Additionally, instruction must be free from bias, including religious doctrine, and provide objective information about all available

[2] CDSS All County Letters communicate notification, information, and clarification about specific policies as well as guidance, instructions, and/or requirements for policy implementation to county social services agencies.

pregnancy options, including abortion; abstinence-only education is not permitted (CAL Educ. Code §§ 51933-51934).

The California Foster Youth Sexual Health Education Act (SB 89)

California enacted the California Foster Youth Sexual Health Education Act (SB 89) as part of the 2017 omnibus health services budget trailer bill[3] (Senate Bill 89). The law built upon previous legislation related to SRH for foster youth as well as CHYA in an effort to improve foster youth's access to comprehensive sexual health education, to remove barriers to SRH services for YFC, and to provide quality SRH training for child welfare professionals, caregivers, and other adults who work with foster youth. SB 89 was written in collaboration with child welfare experts from a variety of agencies and advocacy organizations. It was informed by Constantine et al.'s finding that misinformation and confusion regarding the role of child welfare agencies in supporting SRH for foster youth were barriers to addressing youth's needs and that child welfare professionals felt unprepared to discuss SRH with YFC. The law aims to provide clear directives on roles, responsibilities, confidentiality, and privacy and to ensure child welfare professionals receive training in SRH for foster youth. SB 89 contains four provisions:

(1) *Ensure access to sexual health education.* SB 89 aims to improve foster youth's access to sexual health education by requiring child welfare agencies to ensure YFC receive comprehensive sexual health education. The law requires child welfare agency case managers to verify that youth age 10 and older have received sexual health education that meets the requirements of CHYA, at least once in middle school

[3] Budget trailer bills "implement specific changes to [existing] law in order to enact the State budget" (California State Legislature, n.d., p. 273). Unlike most California bills, which go into effect the following January 1, budget trailer bills are effective immediately upon being signed by the governor.

and least once in high school, and to document this verification in the youths' case plans. The law also requires county child welfare agencies to provide or arrange for sexual health education for YFC who have not received the required education in school (CAL Welf. & Inst. Code § 16501.1).

(2) *Inform youth of their rights and address barriers to services.* SB 89 requires child welfare professionals to inform youth about their SRH rights and to facilitate YFC's access to SRH services by addressing any identified barriers to care. The law specifies that case managers must update care plans annually to verify they have informed foster youth age 10 and older of their rights to access age-appropriate, medically accurate information about SRH, to consent to SRH services, and to receive confidential SRH care (CAL Welf. & Inst. Code § 16501.1). Case managers must also document that they have both provided YFC age 10 and older information on how to access SRH care and "facilitated access to that care, including by assisting with any identified barriers to care, as needed" (CAL Welf. & Inst. Code § 16501.1).

(3) *Develop a sexual health training curriculum for child welfare professionals and foster caregivers.* SB 89 requires CDSS to develop a curriculum to train child welfare professionals and foster caregivers about SRH for foster youth (CAL Welf. & Inst. Code § 16521.5). The curriculum must include (a) YFC's rights to SRH care, sexual health information, and confidential services; (b) how to document sensitive and/or confidential information; (c) case managers' and caregivers' duties and responsibilities to ensure YFC can access SRH services and information; (d) strategies for communicating with youth about SRH; and (e) information about contraception, including referral resources.

(4) *Provide SRH training for child welfare professionals and foster caregivers.* SB 89 requires case managers, group home and short-term residential therapeutic program administrators, juvenile court officers (including judges, commissioners, and referees), and foster caregivers to receive training in SRH for foster youth (CDSS, 2018b). Training must utilize a curriculum that complies with the requirements described in section (3) above.

Strengths and limitations of SB 89. Unlike previous California legislation related to SRH for foster youth, SB 89 was enacted as part of a budget bill. This ensured funding for each of the law's mandates and thus greatly facilitated its implementation. For example, the bill provided counties with funding to pay case managers for the time required to fulfill their new SRH-related obligations as well as funding to provide newly-mandated trainings for child welfare professionals. On the other hand, because SB 89 was part of a budget trailer bill and thus went into effect immediately upon being signed by the governor, key structures, systems, and policy directives needed to fulfil the law's requirements were not in place when SB 89 was enacted. Implementing SB 89 required CDSS to interpret the law and issue directives to child welfare agencies. In September 2017, CDSS issued "A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention," which elaborates on the duties required of case managers by SB 89. In June 2018, CDSS issued ACL 18-61, providing county child welfare agencies with directives for meeting the law's requirements. Work by CDSS, county child welfare agencies, and other organizations to implement the law's provisions is ongoing. For example, as of June 2018, CDSS is still working to create and implement software functionality needed to document SB 89 requirements in electronic case plans (CDSS, 2018b). Training modules for case managers, judicial officers, and foster

caregivers have been developed in implemented in some counties. Because foster care in California is administered at the county level, inter-county heterogeneity in agency structures, resources, priorities, and needs may result in piecemeal and asynchronous implementation of the law.

SB 89 aims to increase YFC's access to quality sexual health education by requiring child welfare agencies to ensure youth have received sexual health education pursuant to CHYA; however, the law does not specify how case managers can or should verify that youth have received this education. ACL 18-61 recommends case managers communicate directly with school officials to confirm whether youth have received the required education (CDSS, 2018b). Like CHYA, SB 89 requires sexual health education at least once during middle school and at least once during high school. The specific timing of this education is otherwise unspecified and left to the discretion of individuals schools or school districts. ACL 18-61 therefore recommends case managers connect youth to sexual health education as "early as possible" to ensure the requirement is met and to allow child welfare agencies sufficient time to make alternative arrangements if necessary (CDSS, 2018b, p. 3). CDSS otherwise does not provide more specific guidance on timing for this requirement. Because SB 89 does not require sexual health education until middle school, YFC may find the sexual health education it requires is still too late for their needs.

SB 89 clarifies the role of county child welfare agencies related to SRH for foster youth. It also clarifies individual case managers' responsibilities in supporting SRH for YFC. The law clearly states that child welfare professionals must provide foster youth with age-appropriate, medically accurate information about SRH. The "Guide for Case Managers" also notes that case managers must ensure youth understand this information by presenting it in an age-,

developmentally-, and culturally-appropriate manner, using interpreter services when needed (CDSS, 2017). The "Guide for Case Managers" also provides case managers with guidance on navigating confidentiality, privacy, caregiver objections, and conflicting biases and personal beliefs.

SB 89 is less clear about the role child welfare agencies and case managers should play in addressing barriers to SRH for YFC, other than to say they should "assist with any identified barriers." ACL 18-61 does not provide further information or guidance on the types of barriers case managers must address, nor does it provide more specific information about the extent of their responsibility to address these barriers. The "Guide for Case Managers" expands on this requirement by describing case scenarios of common and potential barriers, case managers' legal responsibilities, and recommendations for action (CDSS, 2017). Furthermore, it indicates case managers have an obligation to ensure barrier are addressed in a "timely and effective manner" (CDSS, 2017, p. 5) It also indicates case managers have a responsibility to proactively assist youth in obtaining SRH services, e.g., by helping youth make appointments and arranging transportation.

SB 89 aims to address child welfare professionals' reported need for high-quality training in adolescent SRH by developing an educational curriculum and mandating training for a variety of professionals who interact with YFC. The law gives agencies and organizations considerable flexibility in meeting the training requirement. A variety of training programs have been developed or are in development; however, the extent to which training has thus far been implemented across the state is unknown. One evaluation of a SRH training program implemented in the Los Angeles County Department of Children and Family Services (DCFS), the child welfare and protection agency for Los Angeles county, found that although the program

was mandatory for DCFS line staff, only one third of staff had completed the training (Ahrens, Lowry, Udell, Coatney, & Brady, 2019). The long-term effect of these trainings on YFC's SRH is yet to be determined.

As with the state-level policies in other states described above, to date, little is known about whether SB 89 has been implemented as written. The law does not include a specific timeline or deadline for implementation, nor does it designate responsibility for oversight to a particular party or organization. Furthermore, the law does not describe consequences for counties or agencies that do not comply with its mandates.

Training Evaluations

Two SRH training programs developed to train professionals who work with foster youth in California were assessed as part of this policy analysis to evaluate the immediate impact of the trainings. The trainings were conducted for juvenile court officers and healthcare providers, respectively. The evaluations were reviewed by the Seattle Children's Institutional Review Board and determined to be exempt.

Judicial officer training. This evaluation explores juvenile court officers' beliefs and self-efficacy regarding their roles related to SRH for foster youth before and after a SRH training. Participants were a variety of judicial officers, including judges, attorneys, social workers, probation officers, and Court-Appointed Special Advocates.

Methods. An in-person SRH training was developed for a variety of court professionals who work with youth in the foster care system, including judges; attorneys who represent children, parents, and/or agencies; social workers, including court officers and intake and detention control personnel; probation officers; and Court-Appointed Special Advocates, among

others. The content of the training met the requirements of SB 89 as described above. Training sessions ranged from one to three hours in length and primarily utilized a lecture format, using case studies, without practicum. The training was initially piloted between March and May 2018 with court professionals at four sites throughout California. These trainings were sponsored by the Judicial Council of California and provided as part of the implementation of SB 89. Pilot participants represented both urban and rural counties as well as large and small counties. Feedback from participants at these four sessions was used to make iterative changes to the training materials. The final version was then presented to court professionals at eight training sessions in Los Angeles County between July and October 2018. Data from these eight trainings are included in this evaluation as described below.

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

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

Results. Two-hundred fifteen court professionals participated in both pre- and post-training surveys and are included in these analyses.

Participants' roles and responsibilities. As shown in **Table 3**, the most common roles represented in the analyses were social worker (including court officers and intake and detention control personnel; 32%) and child's attorney (22%). Ten participants (5%) indicated they had two or more of the roles listed.

The majority of participants (84%) indicated they had at least one legal responsibility related to SRH for YFC, and 67% reported having more than one responsibility (see **Table 4**). The most commonly reported responsibilities were asking youth about barriers to sexual health care (65%), ensuring youth are provided with information about SRH (64%), and ensuring barriers to SRH services are addressed (62%). The frequencies of other reported responsibilities are summarized in **Table 4**, and the frequencies of reported responsibilities by role are detailed in **Table 5**.

Beliefs and self-efficacy. Ninety percent (n = 195) of participants responded to both pre- and post-training questions about their belief in the ability of compliance with state laws to impact SRH for youth (see **Table 6**). Of these 195 participants, 87% agreed or strongly agreed with the statement "Compliance with state law will make an impact on sexual/reproductive health outcomes for youth in foster care" prior to training; 95% agreed or strongly agreed after training. The proportion of participants who strongly agreed increased significantly from pre- (42%) to post-training (64%), $p < 0.001$.

Ninety percent (n = 194) of participants also responded to both pre- and post-training questions about their preparedness to meet state legal requirements regarding SRH for foster youth (see **Table 7**). Prior to training, only 42% of participants agreed or strongly agreed with

the statement "I have been provided with all the resources and knowledge that I need in order to meet the requirements of state law in my work." After training, a large majority (91%) agreed or strongly agreed with the statement. The proportion of participants who strongly agreed increased significantly from 13% to 45%, $p < 0.001$.

Barriers and needs. Participants were asked to select from a list of potential reasons they may be hesitant to have conversations about sexual health with youth. Participants were able to select all applicable options. Prior to training, the majority of participants (78%) endorsed one or more of the potential barriers to conversation listed (see **Table 8**). The proportion of participants who reported one or more barriers decreased significantly post-training to 69%, $p = 0.008$. The most frequent responses pre-training were not knowing teen clients very well (43%), being unsure as to whether they are supposed to be talking with youth about sex (20%), and the perception that talking about sex is inappropriate given the participant's role (19%). As shown in **Table 8**, the proportion of participants who endorsed five specific perceived barriers decreased significantly post-training. Notably, "I am not sure if I am supposed to be talking with youth about sex" was the second-most commonly reported barrier prior to training but rarely reported (5% of participants) after training.

Participants were also asked to select from a list of potential additional resources, knowledge, and training that would help ensure their ability to meet the SRH needs of foster youth. Participants were able to select all applicable options. Eighty-nine percent of participants (n = 192) identified at least one area of need. As shown in **Table 9**, the most frequent responses were information about referral resources and services in the community (66%) and support around how to effectively communicate with youth regarding sexual health (63%).

Lastly, after training, participants were asked to provide short free-text answers to the

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

Conclusions. The trainings included in this evaluation were primarily attended by social workers (including court officers and intake and detention control personnel), attorneys, and probation officers. Most participants endorsed having multiple responsibilities related to SRH for YFC. Notably, although social workers and probation officers who work with foster youth are legally required to perform all of the duties queried, prior to the training, none of the five duties was universally reported as a legal responsibility by social workers or probation officers. These findings suggest a need to provide social workers and probation officers with clear and specific information about their legal responsibilities under SB 89. Additionally, further evaluation of this training would benefit from querying participants’ perceptions of their responsibilities both before and after training to assess whether the session improves participants’ understanding of their legal obligations. Per SB 89, attorneys are not directly responsible for the duties listed but are required to ensure child welfare agencies are meeting these obligations; that a majority of attorneys indicated responsibility for four of the five requirements suggests many attorneys are aware of their responsibility to provide oversight and ensure these requirements are met.

Additionally, many participants who do not have legal obligations related to SRH under SB 89, including investigators and Court-Appointed Special Advocates, nonetheless frequently endorsed having legal responsibilities to support the SRH of foster youth. This finding suggests many court professionals demonstrate commitment to supporting the SRH of foster youth even when they have no legal obligation to do so. Overall, an obligation to create normalcy around SRH was commonly endorsed by participants in all roles, suggesting many court professionals perceive speaking openly about SRH topics with YFC as an important role for professionals who work with foster youth. Of note is that facilitating transportation to SRH services requested by foster youth was the responsibility endorsed least frequently by social workers and probation officers as well as attorneys, suggesting a significant need to ensure court professionals are aware of this requirement in particular.

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

After training, participants were significantly less likely to report hesitation to have conversations about sexual health with youth in their work; in particular, the proportions of participants who endorsed uncertainty as to whether they are supposed to talk with foster youth about sex, who felt talking about sex with foster youth was not appropriate given their role, and who felt they did not have adequate information about sexual health decreased significantly. However, most participants reported one or more areas of need related to SRH for foster youth after the training. Of note is that each of the areas of need commonly reported after training –

including information about referral resources and services in the community, legal obligations and rights, sexual health, and healthy sexual development as well as strategies for communicating with youth about SRH and addressing related barriers – was included in the training session to some extent, indicating a need for more in-depth training on these topics. This suggests that court professionals would benefit from longer and/or multi-session trainings, the inclusion of practicum, and more specific case studies. Lastly, officers would likely also benefit from ongoing opportunities to discuss their questions and needs with policy experts as well as experts in adolescent SRH.

Healthcare provider training. SRH training for healthcare providers who care for foster youth is not required by SB 89; however, because healthcare providers are sources of SRH information and care for YFC, they are also important targets for training around SRH for foster youth. This report explores healthcare providers' knowledge, attitudes, and self-efficacy around SRH care for foster youth before and after a three-hour training session. Specific training content areas included 1) health disparities among YFC; 2) practical tools and guidance for providing foster-friendly care; and 3) confidentiality, consent, and reporting laws.

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

Participants completed a written 21-item survey before and again immediately after the training. Surveys included seven multiple choice and three true/false questions designed to assess participants' knowledge of the training material. Surveys also included five five-level Likert

items assessing participants' attitudes about providing SRH care for YFC and six five-level Likert items assessing participants' self-efficacy related to providing this type of care.

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

Results. Sixty participants participated in both pre- and post-training surveys and are included in these analyses.

Knowledge. As shown in **Table 10**, participants' knowledge increased significantly overall and for six of ten specific items. The largest increase (45%) was in knowing who to notify if a foster youth reports they have been raped or sexually assaulted, followed by knowing that laws do not prohibit social welfare workers from discussing sexual health practices with youth (+28%), knowing current and former foster youth are eligible for MediCal until age 26 if they had an open case as of their 18th birthday (+27%), knowing most foster youth who become pregnant do not do so intentionally (+23%), and knowing providers are able to share foster youth's SRH information with child welfare workers only if the youth has signed a medical release authorization (+23%).

Participants' knowledge did not change significantly for four items (see **Table 10**). Pre-training knowledge was high for questions related to the prevalence of pregnancy among youth

in foster care (87% of participants answered correctly pre-training), the prevalence of adverse childhood experiences among foster youth (100% correct pre-training), and the age of consent for obtaining SRH services in California (97% correct pretraining) and remained high after training. Only 45% of participants were able to correctly identify all appropriate responses from a list of potential questions to ask when taking a SRH history from foster youth both before and after training.

Overall knowledge increased significantly from a mean of 57% of questions correct on pre-training surveys to a mean of 73% of questions correct on post-training surveys, $p < 0.001$. Mean knowledge also increased significantly for each content domain (see **Table 11**). The pre- to post-training increase in the mean proportion of questions correct was highest for the confidentiality, consent, and reporting laws domain. After training, knowledge was highest for questions related to health disparities among YFC and lower for questions related to providing foster-friendly care and confidentiality, consent, and reporting laws.

Attitudes. Participants' pre- and post-training responses to questions assessing their attitudes about SRH services for foster youth are summarized in **Table 12**.

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

The majority of participants disagreed or strongly disagreed that "informing youth in the foster system about contraceptive options is only marginally helpful in reducing pregnancies

because most foster youth want to become pregnant" both before (79%) and after (85%) training. The proportion of participants who strongly disagreed increased significantly from pre- (34%) to post-training (59%), $p = 0.002$.

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

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

Prior to the training, less than half of participants (49%) disagreed or strongly disagreed with the statement "Healthcare providers should not conduct an abortion procedure on a minor without guardian knowledge or consent," while 26% were neutral. The majority (88%) disagreed or strongly disagreed after training. The proportion of participants who strongly disagreed increased significantly from pre- (28%) to post-training (57%), $p < 0.001$, indicating the proportion of providers who understood that neither guardian notice nor consent is necessary to conduct an abortion was significantly higher after training than before.

Self-efficacy. Mean self-efficacy scores increased significantly from pre- to post-training for five of six items (see **Table 13**). The largest improvement (+0.72) was seen for the item "I

can effectively discuss sexual exploitation and abuse with a youth I am caring for."

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

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

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

should ensure youth choose LARC regardless of historical practices that may make YFC suspicious of these devices, their reported self-efficacy in discussing community suspicions and cultural myths about the negative impacts of LARC with youth was high at baseline and significantly increased from pre- to post-training.

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

Summary of findings from training evaluations. Overall, these evaluations are in keeping with the findings of other studies suggesting a need for SRH training for professionals

who work with foster youth, including those with prior experience working with the foster population. The evaluations suggest such training may effect significant improvements in participants' knowledge, attitudes, beliefs, and self-efficacy.

These evaluations were limited by their small sample sizes and the relative homogeneity in the types of professionals who participated. The healthcare provider training, specifically, was also limited by its low survey response rate. Further evaluation of other types of professionals not commonly represented in these assessments (including judges, Court-Appointed Special Advocates, and county counsel) would provide more robust information on the training's effectiveness among a variety of professionals who work with YFC. Furthermore, these evaluations did not collect data on participant demographics, such as age, gender identity, race/ethnicity, provider type (for healthcare providers), or years in practice. Future training evaluations would benefit from assessing relationships between demographic characteristics and training outcomes. Finally, these evaluations only assessed outcomes immediately after training. Further study is needed to determine whether changes in knowledge, attitudes, beliefs, and self-efficacy persist over time and whether these findings are associated with improved outcomes for foster youth.

Expert Interviews

Further analysis of California state policy related to SRH for YFC was conducted through interviews with experts from a from a variety of public and private organizations in or related to the California child welfare system. Participants were asked about public policy related to SRH for YFC in California, including SB 89. Participants were identified through personal contacts as well as publicly-available agency directories and selected to represent a breadth and depth of

experience and expertise in SRH policy for foster youth. Snowball sampling was used to identify additional experts. Seven experts were invited to complete one-on-one interviews. Six of those invited, representing five agencies and organizations, completed interviews. Participants' roles, agencies, and organizations are summarized in **Table 13**; the agencies and organizations represented are described further in **Appendix E**.

Methods. Interviews were conducted by phone using a semi-structured guide (see **Appendix D**). Extensive notes were taken during the interviews and later analyzed for common themes. Themes present in four or more interviews are described below as common themes. Other themes present in two or more interviews are described as other key themes below.

Common themes.

Consider the logistics of implementation. Nearly all experts discussed the importance of logistics and feasibility related to implementing policy related to SRH for foster youth. Several participants described a need for lawmakers and/or state administrative agencies to develop and disseminate specific, detailed directives for the agencies and organizations responsible for implementing policies. Several participants also described the importance of ensuring the structures and systems required to implement proposed SRH policy are in place; for example, many of California's policies regarding SRH for YFC require case managers to document specific information in a youth's case plan, however, the electronic case plan software used by CDSS did not contain fields for entering the required information when these policies were enacted. Additionally, experts mentioned the sensitive nature of the SRH-related information case managers are required to document and described a need for both clear instructions and software functionality to document confidential information.

***Collaboration*.** Participants commonly described involving stakeholders – including

foster youth and caregivers, advocates, child welfare agencies, and representatives from other related state agencies – in the policy-making process as critical to developing and implementing effective policy. Participants also noted that policymakers considering options for supporting the SRH of YFC would benefit from collaborating with stakeholders from other states who have successfully developed and implemented policy in this area.

Ensure youth in foster care receive sexual health education. All experts emphasized the importance of sexual health education for foster youth, and most described ensuring YFC have access to high-quality, medically acute, comprehensive sexual health education as an important policy target. Several participants noted that SB 89's sexual health education mandate benefited from the recent passage of CHYA, as the state-wide requirement for comprehensive sexual health education facilitates sexual health education for YFC. These participants noted that states without sexual health education requirements are likely to face additional challenges related to providing this education for foster youth. Experts described some logistic challenges related to meeting the sexual health education requirement of SB 89 and commented on the importance of including specific directives for fulfilling such education requirements; for example, if a policy requires case managers to "verify" YFC have received sexual health education in school, the policy should specify how a case manager should or must verify this information. Participants also emphasized the importance of collaboration with state departments of child welfare and education when creating and implementing policy related to sexual health education for YFC.

Ensure foster youth understand their sexual and reproductive health rights. Experts frequently noted that all young people in California – including YFC – have extensive and progressive SRH rights; however, YFC are frequently not aware of their rights and therefore may not exercise them. Several participants discussed the importance of ensuring YFC understand

their SRH rights, including the rights to consent to (or refuse) SRH care, to obtain SRH services without the knowledge or consent of their caregivers, and to keep their SRH information private.

Ensure adults who work with foster youth understand youth's sexual and reproductive health rights and are equipped to discuss sexual and reproductive health with youth. Similarly, experts observed that adults who work with YFC are often erroneously under the impression that because youth are "in the system," they do not have the same SRH rights as non-foster youth. Participants stressed the need to ensure those who work with YFC understand youth's legal rights around consent, confidentiality, and privacy. Stakeholders also emphasized that adults who work with foster youth must be able to communicate clearly and comfortably with YFC about their SRH rights as well as about other SRH topics. The majority of participants described a critical need for providing formal training on a variety of SRH topics for child welfare professionals and other adults who interact with YFC.

Consider sexual and reproductive health in the broader context of foster youth's environments and experiences. Nearly all interview participants emphasized that SRH do not exist in a vacuum but are influenced by youth's sociopolitical environments and lived experiences. Participants noted that intersecting oppressions, including poverty, racism, and the intersections of the child welfare and criminal justice systems, often limit YFC's ability to decide the course of their reproductive lives. Participants observed that the child welfare system – and society as a whole – frequently blame individual YFC for poor reproductive health outcomes, and this blame is reflected in policies and interventions that, intentionally or unintentionally, portray YFC as deviant. Experts stressed the need to examine structural factors that affect YFC's SRH and to work toward dismantling systemic barriers to sexual and reproductive well-bring rather than vilifying the behavior of individual youth.

Other key themes.

Inclusivity. Multiple experts discussed the importance of creating SRH policies that are inclusive of all genders and sexual orientations as well as youth from all racial, ethnic, and cultural backgrounds.

Acknowledge histories of reproductive coercion, especially among people of color. Interview participants stated that policymakers must be informed about the reproductive injustices experienced by many people of color, poor people, and system-involved people in the United States, including coercive policies aimed at preventing pregnancy and childbearing among these and other people, and strive to create policies that empower young people to achieve their own reproductive goals rather than simply ensure all YFC are using contraception.

Support youth in establishing relationships with trusted adults. Lastly, experts stressed the importance of policies and programming that support youth in developing meaningful, lasting relationships with trusted adults. Participants described such relationships as instrumental in helping foster youth achieve both their reproductive goals and more general well-being; however, experts also acknowledged the difficulties associated with using policy to achieve this goal, noting that genuine relationships cannot be mandated and that building trust takes time.

Review of Recommendations From the Literature

In addition to the training evaluations and expert interviews described above, this analysis was informed by a review of extant literature on SRH policy for YFC. Scientific and legal literature were identified by searching the University of Washington libraries. Original research was included if it evaluated existing SRH policy for foster youth and/or generated policy recommendations related to SRH for YFC. In addition, relevant reports from advocacy

and policy organizations were identified via library and web searches. Additional sources were identified by searching the reference lists of the documents discovered by the search strategies described above. A total of eight sources, including three qualitative research studies, four organizational reports, and one legal review, were identified and their specific recommendations reviewed. Recommended principles, best practices, and policies from each source are provided in **Appendix F**. Recommendations appearing in three or more sources are listed as key themes below.

Key Themes

Principles and best practices.

Involve foster youth in decision-making and incorporate youth voice. Literature commonly recommends engaging YFC in the policymaking process and incorporating youth's perspectives, ideas, and recommendations into policy decisions (Ahrens et al., 2016; Love et al., 2005; Young, 2010).

Be inclusive and affirming of all identities. Literature on SRH policy for YFC stresses the importance of policies that are inclusive and affirming of all sexual orientations, gender identities and expressions, races, ethnicities, and cultures (Ahrens et al., 2016; Ahsan, 2018; Sexual Health Youth Advocacy Coalition, n.d.; Young, 2010).

Specific policies.

Ensure youth in foster care have access to sexual health education. The literature overwhelmingly recommends that states mandate and provide comprehensive, medically accurate sexual health education for foster youth (Ahsan, 2018; Constantine et al., 2009; Schuyler Center for Analysis and Advocacy, 2009; Sexual Health Youth Advocacy Coalition,

n.d.; Wallis, 2014; Young, 2010).

Develop and fund programming and services that support pregnant and parenting foster youth. Recommendations to create and fund programming and support services for pregnant and parenting foster youth are common in the literature. Specific recommendations include providing access to an extensive range of medical care, including pregnancy testing, abortion, prenatal care, childbirth care, and postpartum care as well as support services such as parenting classes, home visits, and mentoring programs. The literature also stresses the importance of providing unbiased pregnancy options counseling, supporting pregnant youth in making their own informed choices regarding their pregnancies, and supporting parenting YFC in the postpartum period and beyond (Ahsan, 2018; Constantine et al., 2009; Schuyler Center for Analysis and Advocacy, 2009; Sexual Health Youth Advocacy Coalition, n.d.).

Provide sexual and reproductive health training for adults who work with foster youth. The literature also overwhelmingly recommends SRH training for foster caregivers and child welfare professionals. Specific recommended training targets include general information on adolescent SRH, information on YFC's SRH rights, caregivers' and professionals' roles and responsibilities, and strategies for communicating effectively with youth about SRH (Ahrens et al., 2016; Constantine et al., 2009; Love et al., 2005; Schuyler Center for Analysis and Advocacy, 2009; Sexual Health Youth Advocacy Coalition, n.d.; Young, 2010).

Collect data on sexual and reproductive health outcomes among youth in foster care. Several authors emphasized the lack of data on SRH outcomes among YFC and recommend collecting state- or nation-wide data on SRH outcomes in the foster population (Love et al., 2005; Schuyler Center for Analysis and Advocacy, 2009; Young, 2010).

Recommendations for Washington State

As described above, Washington has a legal responsibility to meet the medical and educational needs of foster youth. The state has also declared a commitment, most notably through the Braam settlement, to support the health and well-being of YFC. Enacting a comprehensive, state-wide policy intended to protect YFC's SRH rights and support their sexual and reproductive well-being would be a critical step toward achieving these responsibilities and objectives.

Synthesis of the above analysis of existing Washington law, policy, agencies, and structures as well the analyses of the policies and experiences of other states and recommendations from the literature reveals a critical need for policies that (1) clearly define YFC's SRH rights; (2) ensure YFC and the adults who care for them understand these rights; (3) ensure YFC have access to comprehensive SRH services, including sexual health education; (4) clearly define the SRH-related roles and responsibilities of adults who care for YFC; and (5) provide adults who care for and work with YFC with the information and skills necessary to support the SRH of foster youth. Additionally, critical appraisal of the analyses above reveals a need for such policies to be inclusive, affirming, and rights-based with goals of supporting the overall SRH of YFC and empowering foster youth to achieve their reproductive goals. Thus, the following guiding principles and specific policies are recommended for policymakers in Washington state:

Guiding Principles

Frame policy around a positive, rights-based definition of sexual and reproductive health. Policy should be grounded in an affirming, rights-based definition of SRH and strive to

ensure the complete sexual and reproductive well-being of YFC rather than focus on negative definitions of SRH or set objectives related solely to the absence of STIs, pregnancy, or disease.

Seek input from foster youth. Policy decisions should be guided by the experiences, needs, and priorities of YFC. Policymakers should seek input from foster youth and former foster youth and appropriately compensate YFC who participate in the policymaking process for their time and expertise.

Seek input from a variety of stakeholders. Policymakers should also seek input from stakeholders from a variety of agencies and organizations, both within and beyond Washington state. Policy decisions should be informed by foster caregivers, key state agencies (including DCYF and the Washington State Office of Superintendent of Public Instruction), child welfare experts, medical and public health professionals, sexual health educators, other experts in SRH, and advocacy organizations. Policymakers would also benefit from consulting and collaborating with experts from other states that have successfully implemented SRH policies for YFC, including New York and California.

Ensure policies are inclusive. Policy must be inclusive and affirming of all identities, including race, ethnicity, ability status, sexual orientation, gender identity, and gender expression. Policy should strive for cultural humility and avoid religious doctrine. Policymakers should avoid hetero- and cis-normative language, principles, and standards. Policy must also be inclusive of young adolescents in ways that are age- and developmentally-appropriate.

Support youth in establishing and realizing their family planning goals. The state should not assume all pregnancies among YFC are unwanted and/or undesirable and should avoid prescriptive policies aimed solely at preventing pregnancy, childbearing, and parenting among YFC. Instead, policies should affirm YFC's right to decide if, when, and with whom to

bear children and aim to support youth in establishing and achieving their own family planning goals by providing access to accurate sexual health education and a full spectrum of high-quality SRH services. Washington should ensure YFC who desire contraception have access to their contraceptive method(s) of choice; however, the state should avoid quotas or targets for rates of overall contraceptive use or use of particular methods. The state should also avoid offering incentives (such as financial compensation to youth and/or healthcare providers) that might intentionally or unintentionally pressure YFC into using one form of contraception over another. Policies should also uphold YFC's right to raise any children they have in safe, nurturing environments by providing support and services for pregnant and parenting youth.

Acknowledge and address contextual and structural influences on sexual and reproductive health for foster youth. Policies aimed at improving SRH for YFC must acknowledge that intersecting structural oppressions – including poverty and social marginalization as well as inequities in the healthcare, education, child welfare, and criminal justice systems – profoundly affect YFC's ability to realize their reproductive rights and determine the course of their reproductive lives. SRH-specific policy should be accompanied by policy efforts to eliminate disproportionality and disparities in the foster system as well as efforts to reduce poverty and dismantle structural injustices, including systemic racism and gender- and sexual orientation-based discrimination. Furthermore, SRH policies should target systemic and structural barriers to SRH for YFC rather than individual risk factors or behaviors.

Specific Policies

Codify foster youth's sexual and reproductive health rights in state law. The state should clearly affirm that YFC have same rights as non-foster youth to consent to confidential

contraception, abortion, STI-related, and prenatal services. Furthermore, the state should clearly define YFC's other SRH rights in state law; although DCYF has published a list of the rights of children and youth in foster care in both agency and youth-facing documents, a complete list of rights is not specifically codified in state law and thus may be subject to change, loss, and/or intentional or unintentional neglect.

Washington should pass a law affirming that YFC have the following SRH-related rights (adapted from Ahsan [2018, p. 8] and DSHS [2015, p. 2]):

- The right to obtain or refuse the full of spectrum of SRH services across the reproductive lifespan, including but not limited to the right to obtain the following services without the consent or notification of a parent, guardian, or caregiver:
    - contraception at any age
    - abortion at any age
    - prenatal care at any age
    - testing and treatment for sexually transmitted infections, including HIV, if 14 years of age or older
- The right to make decisions about their SRH
- The right to comprehensive, medically accurate information about SRH
- The right to keep information about their SRH experiences and choices confidential, unless they or someone else is at risk of harm
- The right to care that affirms their sexual orientation, gender identity, and gender expression
- The right to receive timely support for their SRH needs
- The right to be safe and protected from sexual, physical, and emotional harm

- The right to parent, which includes the opportunity to be with their children and to make fundamental decisions about their upbringing

This recommendation could be met by the passage of a SRH-specific law or a comprehensive Foster Youth Bill of Rights law.

Ensure foster youth are informed of their sexual and reproductive health rights. DCYF currently requires caseworkers to inform YFC of their rights annually beginning at age 12; this practice is not specifically required by law. The state should establish a legal requirement for DCYF to notify YFC of their SRH rights in a way youth understand. Because many young adolescents in foster care are sexually experienced, youth should be notified of their SRH rights starting at age 10. Additionally, because the understanding, experiences, and SRH needs of young adolescents, in particular, may change rapidly, it is recommended that DYCF be required to inform YFC of their SRH rights every six months between the ages of 10 and 16 years and annually thereafter.

Additionally, DCYF should update "Your Rights, Your Life: A Resources for Youth in Foster Care" and the "Rights of Children and Youth in Foster Care" declaration form (as well as any other pertinent documents) to include all of the rights listed above.

Establish a working group to develop a plan to ensure youth in foster care receive sexual health education. Washington should ensure YFC receive age-appropriate, medically accurate, comprehensive sexual health education beginning in early childhood. Many YFC may receive sexual health education in school; however, others are likely unable to receive this education in school because of placement and school instability as well as the absence of a state-wide requirement for schools to provide sexual health education. Developing and implementing a plan to provide sexual health education for all YFC will require buy-in and input from the state

child welfare and education systems. Washington should therefore establish and fund a working group specifically tasked with developing a plan to ensure YFC receive age-appropriate, medically accurate, comprehensive sexual health education. The working group should include stakeholders from state and local child welfare agencies, state and local education agencies, and schools as well as experts in sexual health education. The group should be directed to determine the need for out-of-school sexual health education for YFC, to explore options for providing out-of-school education to those who need it, and to make specific recommendations to the Washington Legislature as to how to best ensure YFC receive sexual health education. The working group should be given a deadline for reporting its findings and recommendations to the Legislature.

Clearly define the sexual and reproductive health-related roles and responsibilities of the state, foster caregivers, and professionals who work with foster youth. Washington should establish policy affirming its responsibility to protect the SRH rights of YFC and support youth in realizing these rights. The state must fund and ensure access to a comprehensive range of SRH services for foster youth. Furthermore, policy should clearly state that foster caregivers and DCYF caseworkers have, at a minimum, the following responsibilities related to SRH for foster youth:

Foster caregivers:

- To meet any requirements for SRH training established by law or DCYF policy
- To answer questions about SRH from youth in their care with information that is medically accurate and free from religious or other bias, or, if unable or unwilling to do so, to refer youth to someone who can
- To facilitate YFC's access to SRH services by assisting youth in making

appointments, providing transportation to and from SRH services, and accompanying youth to SRH-related appointments, when requested by youth

DCYF caseworkers:

- To meet any requirements for SRH training established by law or DCYF policy
- To inform YFC of their SRH rights as required by law or DCYF policy
- To answer questions about SRH from youth in their care with information that is medically accurate and free from religious or other bias, or, if unable or unwilling to do so, to refer youth to another professional who can
- To provide YFC with information about where they can receive SRH services
- To ask YFC about barriers to SRH services at least every six months and to address certain barriers, including but not limited to transportation, health insurance-related issues, school or work absences, and objections from foster caregivers
- To facilitate YFC's access to SRH services by assisting youth in making appointments, providing transportation to and from SRH services, and accompanying youth to SRH-related appointments, when requested by youth
- To keep YFC's SRH information private and to document confidential SRH information in a secure file accessible only to the caseworker
- To notify Child Protective Services and/or law enforcement of sexual abuse or violence, per state mandated reporting laws

Update the Child Health and Education Tracking program to include sexual and reproductive health. Although existing CHET procedures do not preclude assessment of SRH, it is not clear that they explicitly require it. The CHET program should be updated, if necessary, to require assessment of SRH for youth 10 years of age and older. DCYF should develop a

standardized SRH screening assessment tool to be used as part of routine CHET assessments; alternatively, DCYF could use or adapt an existing evidence-based tool. As with other CHET screening findings, findings of initial CHET SRH assessments should inform case plans designed to meet YFC's needs; however, results and plans related to SRH must be kept confidential.

Ensure those who work with youth in foster care receive medically accurate, comprehensive sexual and reproductive health training. The state should mandate, by law, SRH training for foster caregivers, juvenile court officers, and child welfare agency professionals, including those in supervisory and administrative roles and those who work directly with foster youth. Training curricula should include information on basic SRH, the SRH rights of YFC, and the roles and responsibilities of those being trained with an emphasis on confidentiality. Trainings should developed with or reviewed by medical or public health professionals to ensure medical accuracy as well as lawyers or policy experts to ensure legal accuracy. Programs should utilize a variety of modalities, including in-person training seminars, webinars, and written reference materials, to provide both an initial comprehensive training curriculum and continuing education on at least an annual basis. Trainings should be evaluated for effectiveness, using both quantitative data and qualitative feedback from participants, and adapted as necessary to meet the needs of both training participants and the youth they serve.

Develop and fund programs to support pregnant and parenting foster youth. The SRH rights of pregnant foster youth – including the rights to comprehensive, medically accurate information and counseling, to abortion services, and to prenatal and postpartum care – should be codified in state law as described above. In addition, the state should develop and fund programs to support pregnant and parenting youth in achieving their desired pregnancy outcomes and raising any children they have in safe, nurturing environments. Specific programming could

include financial supplements during and after pregnancy, childbirth and parenting classes, nurse home visits for the first year of life for parenting youth and their children, and subsidized child care. Washington should consider establishing a working group to assess the needs of pregnant and parenting youth and prioritizing funding based on the group's findings.

Establish a permanent Office of Foster Care Health in DCYF. Finally, the Legislature and/or DCYF should permanently establish an Office of Foster Care Health within DCYF. The office should include experts from the fields of medicine, public health, healthcare administration, and child welfare. Like the original Foster Care Health Unit of 2006, the Office should be charged with overseeing, coordinating, and improving healthcare services, including SRH care services, for YFC. The Office might also be charged with overseeing the implementation of state-level SRH policy for foster youth; for example, the Office should work with policymakers and stakeholders to establish clear and realistic timelines for the implementation of the policies recommended above and to ensure policymakers and agencies meet these timelines. Additionally, the Office should collect data on SRH outcomes among YFC in an effort to better understand and meet the SRH needs of foster youth. Data collection should include aggregate information on rates of STIs and pregnancy as well as information on the number of youth who request and receive SRH services. The data would allow the Office – and the foster system – to tailor its services in response to YFC's needs. In addition, the Office should be charged with evaluating or overseeing the evaluation of SRH training programs for foster caregivers, juvenile court officers, and child welfare agency professionals as described above. Such data is of critical importance in the evaluation of the afore recommended SRH policies.

Conclusions and Considerations for Implementation

Foster youth experience disparate SRH outcomes relative to their non-foster peers. Many of the factors contributing to these disparate outcomes, including barriers to quality sexual health education and services, may be amenable to policy intervention at the state level. Such policies must be inclusive, affirming, and rights-based with a goal of supporting the overall SRH of YFC rather than simply reducing rates of STIs or pregnancy.

The experiences of other states, along with limited research in this area, indicate a need for policies that clearly define both the SRH rights of YFC and the SRH-related responsibilities of the agencies and professionals who work with foster youth. Codifying the SRH rights of foster youth and the SRH-related responsibilities of the state, foster caregivers, and professionals who work with foster youth into state law as described above would be an important first step toward a comprehensive state-level effort to support the SRH of foster youth in Washington state and would likely require little more than political will.

The findings of this analysis also indicate a critical need to create and sustain the systems, structures, and programs necessary to ensure the SRH rights of YFC are upheld. Some of the specific recommendations above, such as requiring DCYF to inform YFC of their SRH rights periodically beginning at age 10 and adapting CHET screening forms to include SRH information, will require relatively minor changes to existing procedures. Other recommendations, including requiring foster caregivers and DCYF caseworkers to fulfill certain roles and responsibilities related to SRH, will require significant changes at both the agency and personnel levels. Such changes are likely to require a considerable amount of time to implement and will require buy-in from a variety of stakeholders at all levels. Additionally, those who work with YFC will require SRH training as described above in order to successfully fulfill their new

SRH-related responsibilities. Developing, implementing, and evaluating this training are also likely to require a considerable amount of time as well as some financial investment from the state; Washington would benefit from utilizing and/or adapting training materials developed by other states and by collaborating with other states to perform ongoing evaluation of such training.

This analysis also finds a clear need for policies that ensure YFC have access to comprehensive sexual health education. Mandating and providing comprehensive sexual health education for foster youth in Washington may prove difficult given the absence of a general state-wide legal requirement for sexual health education. Establishing a foster youth sexual health education working group as described above is likely to require considerable time and money. Nonetheless, providing foster youth with high-quality, medically accurate, comprehensive sexual health education is of the utmost importance to supporting the SRH of YFC. Investing in this process is necessary for the success of all of the other policy recommendations described above.

Policymakers and those charged with implementing SRH policy should anticipate that some foster caregivers and professionals may object to one or more of the policies recommended above or have personal beliefs or biases that conflict with the recommended roles and responsibilities. SRH training for caregivers and professionals should therefore discuss the importance of recognizing one's biases and beliefs; training should also clearly state caregivers' and professionals' legal obligations to uphold YFC's rights. Additionally, DCYF should establish and disseminate procedures for caregivers and child welfare professionals who may object to their SRH-related roles and responsibilities as California did in "A Guide for Case

Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention."

Enacting and implementing the policies recommended in this analysis will require collaboration between policymakers, state and local agencies, and medical and public health professionals, among others. An Office of Foster Care Health in DCYF could serve to coordinate and oversee the implementation of state-level SRH policy as described above. Furthermore, the paucity of information about other states' success – or lack thereof – in implementing SRH policy for foster youth highlights the importance of program evaluation as well as collection of data related to SRH outcomes among YFC. An Office of Foster Care Health could fill these critical roles. Establishing a permanent Office of Foster Care Health would require Washington to commit to funding professionals from a variety of fields as described above. This investment would allow the state to ensure SRH policies are implemented as intended and would support ongoing evaluation and improvement of these policies.

Washington has a legal obligation to meet the medical needs of its foster population; it has also made a commitment to support the well-being of the youth in its care. Additionally, the state has a responsibility to support all people's fundamental human rights, including those related to SRH. Adopting policies aimed at ensuring YFC's SRH rights are maintained would be a critical step toward the state's obligations to its youth. Furthermore, because SRH are integral to the overall health and well-being of individuals and societies, enacting policies that support the SRH of foster youth is likely to have far-reaching positive impacts on both the immediate and long-term health and well-being of YFC as well as the health and well-being of their families and their communities.

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Table 1. Washington state law relevant to sexual and reproductive health for youth in foster care.

Code	Summary of relevant content
RCW § 74.13.031	DCYF must develop, administer, supervise, and monitor services for the protection and care of youth in foster care DCYF has the authority to provide routine and necessary medical, dental, and mental health care for foster youth
RCW § 74.14A.025	Washington shall promote family-oriented services and supports that respond to what individuals and families say they need, and meet those needs in a way that maintains their dignity and respects their choices
RCW § 74.14A.050	DCYF is required to develop programs that effectively address the educational, physical, and medical needs of children and youth in need of long-term care, including those in foster care for two years or more and those with multiple foster placements All youth entering the foster system must receive an evaluation of their long-term needs within 30 days of placement

Table 2. Washington Department of Children, Youth, and Families practices and procedures relevant to sexual and reproductive health for youth in foster care.

Title	**Purpose**	**Summary of relevant policy content**
43092. Child Health and Education Tracking (CHET)	To identify youth's long-term needs at initial placement by evaluating their well-being; to develop an appropriate case plan	DCYF must perform an in-person child health and education tracking screen within 30 days of original placement for all children who are expected to remain in the care of the Children's Administration for 30 days or more
43102. CA Responsibilities to Dependent Youth 12 and Older	To help YFC age 12 and older understand the Children's Administration's duties and responsibilities while the youth is in care	DCYF caseworkers must provide YFC with a copy of "Your Rights, Your Life: A Resources for Youth in Foster Care" and obtain youth's signature on the "Rights of Children and Youth in Foster Care" declaration form (see **Appendix B**) within 30 days of the youth's 12th birthday and annually thereafter
4517. Health Care Services for Children Placed in Out-of-Home Care	To ensure YFC receive necessary healthcare services, including an initial health screen, ongoing well-child care, immunizations, and dental care	DCYF caseworkers must ensure YFC (a) see a medical provider for an initial health screen within five days of entering foster care, (b) receive an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination within 30 days of entering foster care, (c) receive ongoing EPSDT examinations annually, and (d) receive any healthcare services recommended by a medical provider
4520. HIV/AIDS Support Services	To provide YFC in appropriate HIV/AIDS services	DCYF must provide YFC who are HIV positive or at risk for HIV with coordination, information, and referral services

Table 3. Judicial officer training participants' roles (N = 215).

Role	**n**	**%**
Social worker (includes court officers and intake and detention control personnel)	69	32%
Child's attorney	47	22%
Probation officer	34	16%
Investigator	20	9%
Court-Appointed Special Advocate	8	4%
County counsel	1	<1%
Other	34	16%
No answer	12	6%

Table 4. Judicial officer training participants' legal responsibilities related to sexual and reproductive health for youth in foster care.

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

Table 5. Judicial officer training participants' legal responsibilities by role.

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

*Includes child's attorneys and county counsel
**Court-Appointed Special Advocate

Table 6. Judicial officer training participants' beliefs about the statement "Compliance with state law will make an impact on sexual/reproductive health outcomes for youth in foster care" (N = 195).

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

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

Table 7. Judicial officer training participants' responses to the statement "I have been provided with all the resources and knowledge that I need in order to meet the requirements of state law in my work" (N = 194).

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

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

Table 8. Reasons judicial officer training participants may be hesitant to have conversations about sexual health with youth in their work.

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

Table 9. Other resources, knowledge, and/or training that would help ensure judicial officer training participants' ability to meet the sexual and reproductive health needs of foster youth.

Response	**n**	**%**
Information about referral resources and services in the community	141	66%
Support around how to effectively communicate with youth regarding sexual health	136	63%
Information about legal obligations and rights	107	50%
Information about sexual health and "healthy sexual development"	102	47%
Information about the barriers to care that foster youth face	99	46%
Other	10	5%
No answer	23	11%

Table 10. Proportion of healthcare provider training participants who answered specific knowledge questions correctly pre- and post-training.

Knowledge question	**Answer**	**Pre-training % correct**	**Post-training % correct**	**Change**	***p***
If a foster youth under my medical care reports to me that they have been raped or sexually assaulted, I should immediately notify:	Child Protective Services (CPS)	17%	62%	+45%	<0.001
Which is not a factor contributing to high rates of unintended pregnancy among foster youth in the state of California?	Laws prohibiting social welfare workers from discussing sexual health practices with youth	42%	70%	+28%	<0.001
Current and past foster youth are eligible for MediCal:	Until the age of 26 if they had an open case as of their 18th birthday	60%	87%	+27%	<0.001
True or false: Most foster youth who become pregnant do so intentionally.	False	70%	93%	+23%	<0.001
A caseworker and attorney for a foster youth under your care request you share the youth's sexual and reproductive health information. You are:	Able to share the information if you have a signed medical release authorization from the youth on file	30%	53%	+23%	0.002
When parental involvement is not believed to be harmful, guardians have a right to be informed about the following treatment received by youth in their care:	Emergency and sexual assault	18%	37%	+19%	0.011
True or false: Nearly half of foster youth have been pregnant at least once by the age of 19.	True	87%	92%	+5%	0.159

Table 10 continued.

Knowledge question	**Answer**	**Pre-training % correct**	**Post-training % correct**	**Change**	***p***
Which of the following are appropriate questions to ask when taking a sexual and reproductive health history from a foster youth? Check all that apply.	*Multiple*	45%	45%	0	
True or false: In the state of California, all minors 12 and older are legally allowed to consent to sexual health services without parental notification.	True	97%	97%	0	
Compared to non-foster youth, teens in foster care are:	At higher risk of experiencing one or more negative reproductive health problems as a result of adverse childhood experiences	100%	98%	-2%	0.321
Overall		57%	73%	+16%	<0.001

Table 11. Proportion of healthcare provider training participants who answered specific knowledge questions correctly by content domain.

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

Table 12. Healthcare provider training participants' attitudes about sexual and reproductive health services for foster youth before and after training.

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

**p*-value for pre-training to post-training change is 0.007
***p*-value for pre-training to post-training change is 0.002
****p*-value for pre-training to post-training change is <0.001

Table 13. Healthcare provider training participants' mean self-efficacy scores before and after training.

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

Table 14. Agencies, organizations, and roles represented in expert interviews.

Agencies/organizations represented	**Roles represented**
• Alliance for Children's Rights • Children's Law Center of California • Los Angeles County Department of Children and Family Services • National Center for Youth Law • The Children's Rights Project of Public Counsel Law Center	• Attorney • Policy Associate • Program Manager • Social Worker

Appendix A

List of Abbreviations

ACL	All County Letter
AB	Assembly Bill
CA	Children's Administration
CDSS	California Department of Social Services
CHET	Child Health and Education Tracking
CHYA	California Healthy Youth Act
DCFS	Los Angeles County Department of Children and Family Services
DCYF	Washington Department of Children, Youth, and Families
DSHS	Washington Department of Social and Health Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HHS	United States Department of Health and Human Services
LARC	Long-acting reversible contraception
RCW	Revised Code of Washington
SB 89	Senate Bill 89 (the California Foster Youth Sexual Health Education Act)
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
WAC	Washington Administrative Code
YFC	Youth in foster care

Appendix B

Washington Rights of Children and Youth in Foster Care Declaration Form

Washington State Department of Social & Health Services
Transforming lives

CHILDREN'S ADMINISTRATION

Rights of Children and Youth in Foster Care

As a child or youth in foster care, I have the right to know:

- Why I am in foster care.
- How the foster care system works.
- The efforts to reunify me with my family.
- The expectations of my foster caregiver.
- The purpose of a case plan and the contents of my case plan.

I have the right to:

Safety and Well Being
Be protected from abuse and neglect.
Be treated fairly and equally, whatever my gender, gender identity, race, religion, ethnicity, national origin, disability, medical problems, or sexual orientation and be addressed by the gender pronoun I prefer.
Have my basic needs met (food, clothing, shelter, health care, and education).
Participate in "normal" childhood activities (overnights with friends, after-school activities and sports).
Have space for storing my clothing and belongings.
Have the right for my case file and personal information to be confidential and kept in a secure place. Discussions of my information should only occur with designated individuals directly involved with my case plan.
Be free from cruel, frightening, or unsafe discipline.
Practice my own religion or not at all.
Report abuse, neglect, exploitation, or violation of my personal rights without fear of punishment, interference, or coercion.
Be referred for legal services to determine whether an application for Special Immigrant Juvenile Status shall be submitted on my behalf to the Immigration and Naturalization Service.
Court Proceedings
Have someone appointed to represent my best interests in my dependency case, such as a Guardian Ad Litem (GAL) or a Court Appointed Special Advocate (CASA).
Request an attorney or have someone request one on my behalf at any age.
Have my case reviewed in court every six months.
Be notified of and participate in my hearings, if I am 12 or older.
Be notified that I can request an attorney to protect my legal rights and represent what I want, if I am 12 or older.
Be appointed an attorney six (6) months after my parents' parental rights have been terminated.
Be appointed an attorney if I am in Extended Foster Care.
Access and review my case records.
Be consulted about my permanent plan, if I am 14 or older.
Invite two (2) people of my choice to my Permanency Planning meetings, if I am 14 or older.
Placement and Visitation
Be placed in a residence where I am safe, that can meet my needs, and provide appropriate privacy for my personal needs.
Be placed in a home with my siblings whenever possible.
Be placed with a willing and able relative or suitable adult I know and who I am comfortable with, whenever possible and appropriate.
Have regular and frequent contact or visits with my parents, unless otherwise ordered by the court.
Visit my parents and siblings. These visits cannot be limited as punishment for my behavior.
Maintain regular contact or visits with siblings when separated, unless the court orders that contact or visits are not appropriate.
Initiate and receive private phone calls and letters, unless otherwise determined by the court.
Ask the court if I can move back home even if my parents' parental rights have been terminated and three (3) years have passed since termination (and to have an attorney appointed to help me with the request).

Education
Attend school.
Remain in the same school even when I move to a foster home, when it is practical and in my best interest.
Enter school within 3 days of placement into foster care or placement change.
Have an Educational Liaison at my court hearings under certain circumstances.
Healthcare
Be informed of my health needs, medications, and medical history.
Have annual well-check exams.
Have dental exams every 6 months through age 18 and annually thereafter until age 26.
Be informed of the benefits and risks of any and all medicines, vitamins, or herbs that are prescribed or recommended to me.
Agree to or disagree to take any or all medicines, vitamins, or herbs; unless the court says I must take them.
Obtain or refuse reproductive health care, including birth control and/or counseling regarding birth control, without consent or knowledge of a parent or guardian.
Receive outpatient mental health treatment without consent or knowledge of a parent or guardian if I am over the age of 13.
Receive outpatient substance abuse treatment without consent of a parent or guardian if I am over the age of 13.
Obtain tests and treatment for sexually transmitted infections without consent of a parent or guardian if I am age 14 or older.
Know Children's Administration's duties and responsibilities if I am pregnant or a parenting foster youth and that my needs will be addressed and services will be provided.
Transitioning Out of Foster Care / Extended Foster Care
Develop a transition plan for moving out of foster care.
Obtain my consumer credit report annually starting at age 14 until I turn 18.
Know in advance what my options are on my 18th birthday if I am still in foster care.
Know and understand all the components of the Extended Foster Care program.
Enter / re-enter Extended Foster Care one time prior to my 19th birthday.
Refuse Extended Foster Care or opt out at any point.
Be provided my vital documents when needed and upon leaving foster care, including birth certificate, social security card, Washington State Identicard (ID), medical insurance information, and a copy of my health and education records.
Receive medical coverage through state health insurance (Medicaid) until age 26, if I was a ward of the State on my 18th birthday.
Know how to request my case records once I turn 18.
Signatures
I acknowledge that my rights have been provided and explained to me in a way that I can understand.

CHILD / YOUTH SIGNATURE DATE	CA SIGNATURE DATE
☐ Youth declined to sign. ☐ Youth unable to sign.	☐ Youth Rights were provided and explained in an age appropriate way.
PRINT CHILD / YOUTH NAME	PRINT CA NAME

Appendix C

California Foster Youth Bill of Rights

State of California

WELFARE AND INSTITUTIONS CODE

Section 16001.9

16001.9. (a) It is the policy of the state that all minors and nonminors in foster care shall have the following rights:

(1) To live in a safe, healthy, and comfortable home where he or she is treated with respect.

(2) To be free from physical, sexual, emotional, or other abuse, or corporal punishment.

(3) To receive adequate and healthy food, adequate clothing, and, for youth in group homes, an allowance.

(4) To receive medical, dental, vision, and mental health services.

(5) To be free of the administration of medication or chemical substances, unless authorized by a physician.

(6) To contact family members, unless prohibited by court order, and social workers, attorneys, foster youth advocates and supporters, Court Appointed Special Advocates (CASAs), and probation officers.

(7) To visit and contact brothers and sisters, unless prohibited by court order.

(8) To contact the Community Care Licensing Division of the State Department of Social Services or the State Foster Care Ombudsperson regarding violations of rights, to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints.

(9) To make and receive confidential telephone calls and send and receive unopened mail, unless prohibited by court order.

(10) To attend religious services and activities of his or her choice.

(11) To maintain an emancipation bank account and manage personal income, consistent with the child's age and developmental level, unless prohibited by the case plan.

(12) To not be locked in a room, building, or facility premises, unless placed in a community treatment facility.

(13) To attend school and participate in extracurricular, cultural, and personal enrichment activities, consistent with the child's age and developmental level, with minimal disruptions to school attendance and educational stability.

(14) To work and develop job skills at an age-appropriate level, consistent with state law.

(15) To have social contacts with people outside of the foster care system, including teachers, church members, mentors, and friends.

(16) To attend Independent Living Program classes and activities if he or she meets the age requirements.

(17) To attend court hearings and speak to the judge.

(18) To have storage space for private use.

(19) To be involved in the development of his or her own case plan and plan for permanent placement. This involvement includes, but is not limited to, the development of case plan elements related to placement and gender affirming health care, with consideration of their gender identity.

(20) To review his or her own case plan and plan for permanent placement, if he or she is 12 years of age or older and in a permanent placement, and to receive information about his or her out-of-home placement and case plan, including being told of changes to the plan.

(21) To be free from unreasonable searches of personal belongings.

(22) To the confidentiality of all juvenile court records consistent with existing law.

(23) To have fair and equal access to all available services, placement, care, treatment, and benefits, and to not be subjected to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

(24) To be placed in out-of-home care according to their gender identity, regardless of the gender or sex listed in their court or child welfare records.

(25) To have caregivers and child welfare personnel who have received instruction on cultural competency and sensitivity relating to, and best practices for, providing adequate care to lesbian, gay, bisexual, and transgender youth in out-of-home care.

(26) At 16 years of age or older, to have access to existing information regarding the educational options available, including, but not limited to, the coursework necessary for vocational and postsecondary educational programs, and information regarding financial aid for postsecondary education.

(27) To have access to age-appropriate, medically accurate information about reproductive health care, the prevention of unplanned pregnancy, and the prevention and treatment of sexually transmitted infections at 12 years of age or older.

(b) This section does not require and shall not be interpreted to require a foster care provider to take any action that would impair the health and safety of children in out-of-home placement.

(c) The State Department of Social Services and each county welfare department are encouraged to work with the Student Aid Commission, the University of California, the California State University, and the California Community Colleges to receive information pursuant to paragraph (26) of subdivision (a).

(Amended by Stats. 2018, Ch. 385, Sec. 2. (AB 2119) Effective January 1, 2019.)

Appendix D

Expert Interview Guide

1. Can you tell me about the status of sexual and reproductive rights for youth in foster care in your state?

2. Can you tell me about California Senate Bill 89?

3. What is your impression of Senate Bill 89 since it was enacted approximately 18 months ago?

4. What recommendations do you have for the state of Washington in order to improve the sexual and reproductive health of its youth in foster care?

5. Can you tell me about the work that you do?

6. Tell me about the sexual and reproductive health care needs of youth in foster care.

7. What would reproductive justice for youth in foster care look like?

8. Is there anyone else you would recommend I talk to about this issue?

Appendix E

Agencies and Organizations Represented in Expert Interviews

Alliance for Children's Rights
The Alliance for Children's Rights is a Los Angeles-based organization that works to protect the rights of impoverished, abused, and neglected children and youth. The organization provides free legal and advocacy services for children and youth in foster care as well as training and education for those who work with or care for these youth. In fiscal year 2017-2018, the Alliance for Children's Rights provided 28,000 hours of pro bono legal services worth $10.8 million, serving over 7,000 children and youth. The organization is also a leader in fighting for system-wide policy reform related to the rights and well-being of foster youth. It has written and sponsored bills aimed at improving the lives and well-being of foster youth in California. (kids-alliance.org)

Children's Law Center of California
Children's Law Center of California (CLC) is a non-profit, public interest law firm that represents children and youth who have been abused, neglected, or abandoned. CLC serves as court-appointed counsel for children and youth who come under the protection of the Juvenile Dependency Court systems in three California counties. The organization has a staff of nearly 400 attorneys, investigators, paralegals, and support staff and represents approximately 33,000 youth. CLC is also highly active in the California legislative arena and, as of 2017, has sponsored over 28 successful pieces of legislation related to child welfare. (clccal.org)

Los Angeles County Department of Children and Family Services
The Los Angeles County Department of Children and Family Services (DCFS) is a department of the Los Angeles County government and serves as the child welfare and protection agency for the county. DCFS is the largest child protective services agency in the United States. DCFS administers the Los Angeles County foster care system, overseeing one of the largest populations of foster youth in the country; with approximately 20,000 children and youth in foster care at any given time, Los Angeles County has a larger foster care population than 48 states. DCFS also oversees adoption services and provides child protection services for the approximately 2.3 million children in Los Angeles County. In fiscal year 2015-2016, DCFS had 8,800 employees serving 35,000 children monthly, with an annual budget of $2.2 billion. (dcfs.co.la.ca.us)

National Center for Youth Law
The National Center for Youth Law (NCYL) is a non-profit law firm based in Oakland, California, that works to transform public agencies that serve low-income and vulnerable children so these children have opportunities to thrive. NCYL leads campaigns that incorporate litigation, research, public awareness, policy development, and technical assistance to affect change in multiple systems that serve vulnerable children, including the education, child welfare, public health, behavioral health, juvenile justice, and workforce development systems. NCYL partners with and provides services to public agencies, youth, parents and caregivers, attorneys, and advocates across the United States. The organization has sponsored and advocated for a variety of state and federal legislation supporting the well-being of YFC. (youthlaw.org)

The Children's Rights Project of Public Counsel Law Center

Public Counsel is a Los Angeles-based public interest law firm and the largest *pro bono* law firm in the United States. Its staff and over 5,000 volunteers serve more than 30,000 children, youth, families, and community organizations each year. In addition to free legal services, Public Counsel provides training and consultation for individuals and organizations serving those who live in poverty. Public Counsel's Children's Rights Project provides legal services related to wide range of civil needs for low-income children, youth, and families. In addition, the Children's Rights Project provides trainings for attorneys, bench officers and court personnel, case managers, schools, community agencies, youth, and families as well as social work support for children and families in need, including pregnant and parenting youth. The Children's Rights Project is also active in policy advocacy. (publiccounsel.org)

Appendix F

Recommendations from the Literature

Author(s) (Year) **Title** **Study participants/ source of recommendations**	**Recommended principles and practices**	**Recommended policies**
Ahrens et al. (2016) Qualitative evaluation of historical and relational factors influencing pregnancy and sexually transmitted infection risks in foster youth Current and former foster youth	• Use example situations that are relevant to the unique life experiences of YFC and that reflect the effects of past abuse and other adverse childhood experiences on current relationship behaviors (i.e., are trauma-informed) • Use an interactive, group-based format in which an open, non-judgmental atmosphere is cultivated • Be willing to incorporate youths' ideas • Utilize peer facilitators or leaders (e.g., YFC or alumni of foster care) • Include [all] genders • Promote protective norms and attitudes and directly address maladaptive norms and attitudes • Address misperceptions around the safety and efficacy of various birth control methods • Address the perceived link between early life maltreatment and transactional sex • Address perceived difficulties in emotion regulation and its influence on trust appraisal, effective communication, and impulse control • Promote protective factors, including a sense of personal	• Train caregivers and caseworkers about basic sexual health information and how to have conversations about sexual health with the youths they serve

	responsibility and the ability to set and achieve goals	
Ahsan (2018)[4] Sexual and reproductive health of youth in out-of-home care: A policy and practice framework for child welfare Policy analysis organization	• Start young • Be developmentally informed • Be trauma-informed • Protect youth confidentiality and privacy • Be inclusive and affirming • Prepare for the needs of expectant youth in care • Pay attention to young men in care • Promote father engagement • Focus on youth rights	• Ensure YFC's SRH rights are safeguarded • Ensure YFC have access to a SRH ally for support on all issues related to their SRH needs • Ensure case planning and decision-making are structured to be responsive to the SRH needs of youth in addition to their race, ethnicity, sexual orientation, and gender identity and expression • Ensure all YFC receive regular, reliable, and developmentally-appropriate information about SRH • Ensure YFC receive regular, reliable, and developmentally-appropriate SRH care in a timely manner • Ensure sexual assault and violence prevention services are provided to all YFC and youth who experience sexual assault or violence receive timely, quality, trauma-informed care • Support youth in exploring all available options in responding to pregnancy without bias or pressure regarding their choices • Ensure YFC who choose to carry a pregnancy to term receive timely and quality services and supports • Ensure YFC have healthy and supported birth experiences • Ensure YFC are supported during the postpartum period, are assessed for postpartum

[4] For the sake of space, only an outline of the broad policy objectives recommended by Ahsan is provided under "Recommended policies." For further details and dozens of specific policy options recommended to achieve these objectives, see Ahsan (2018).

		depression, and receive timely and quality services accordingly • Ensure pregnant and parenting YFC are supported in both transitioning to adulthood and in their parenting roles
Constantine et al. (2009) Sex education and reproductive health needs of foster and transitioning youth in three California counties Child welfare workers, foster caregivers, and former foster youth	• YFC should have regular access to comprehensive sex education, including but not limited to methods of contraception and HIV and other STD prevention, personal goal setting, positive relationships, and information on what raising a child entails • YFC in their early teens should have access to sex education • Child welfare staff and foster caregivers should routinely initiate discussions with YFC around sexuality, including self-image, relationships, goal setting, planning and decision making, and protection from STDs, unwanted pregnancy, and exploitation • Information and resources, including condoms, should be presented together on-site by child welfare agencies • Recruitment processes for caretakers in foster homes and group homes need to clearly state that YFC must be allowed to attend sex education	• Develop and implement specific policies, plans, and procedures to help prevent pregnancy and STDs and promote sexual health among foster youth, specifying appropriate roles for all adults who care for youth, including social workers and case workers, public health nurses, and foster caregivers • Training should be provided on various aspects of adolescent sexuality and reproductive health for all child welfare staff, including supervisory staff as well as social workers, case workers, and foster caregivers • Policies should be developed to ensure that a full range of services are provided to pregnant youth, including counseling on pregnancy options, assistance in preventing subsequent pregnancies, and linkages to providers of prenatal care
Love et al. (2005) Fostering hope: Preventing teen pregnancy among youth in foster care Child welfare workers, foster caregivers, and foster youth	• Those who design intervention programs for YFC should tap the experiences and perspectives of foster youth • Programs and interventions for YFC must address both primary and secondary prevention of pregnancy • Programs that stress pregnancy prevention should be evaluated specifically for their effectiveness among YFC	• Collect data on teen pregnancy among teens in foster care and the broader child welfare population • Provide foster caregivers with training and support around SRH for YFC • Provide service providers who work with YFC with training and support around SRH for YFC

	• Programs should engage foster peers • Programs should address what motivates teens to become pregnant and what it will take to motivate them to avoid pregnancy • Programs should include boys and young men • Programs should help foster youth create alternatives to young parenting through youth development activities and connections to community organizations • Improve healthcare coordination for foster youth	
Schuyler Center for Analysis and Advocacy (2009) Risking their future: Understanding the health behaviors of foster care youth Policy analysis and advocacy organization	• Ensure that all YFC have access to needed mental health services • Evaluate pregnancy prevention programs for their effectiveness in the foster care population	• Create a state workgroup to develop a plan to reduce teen births and improve outcomes for teen parents and their children with a special emphasis on the needs of YFC • Provide comprehensive training to adults who work with YFC on the sexual risk-taking behavior found in this population • Replicate successful models that provide an array of services for parenting foster youth and their children, including home visiting programs for pregnant and parenting YFC • Provide sex education and access to reproductive health services, including contraceptives, to all boys and girls in foster care • Fund pregnancy prevention and parenting programs that provide coordinated mentoring experiences • Use the National Youth in Transition Database to capture information on pregnant and

		parenting youth and youth who have aged out of foster care; use this information to evaluate programs, identify gaps in services, and further target resources for YFC
Sexual Health Youth Advocacy Coalition (n.d.) The consensus statement on the rights of youth in state custody Coalition of advocacy organizations	• All youth deserve a chance to be happy and healthy, and to grow to be productive members of society • The human rights of youth are equal to those of adults • Youth should be placed in state custody only when it is necessary for their health and safety or the safety of others, and when no less restrictive alternative is feasible • When the state places young people in its custody, it assumes the role of parent to these youth and the obligation to provide for all of their essential health and safety needs, without imposition of a particular religious or ethical viewpoint • All young people have the right to autonomy in expression of their sexual orientation and gender identity, and in decision-making related to their reproductive health	• Ensure the provision of comprehensive, inclusive, medically accurate, trauma-informed, and LGBTQ-affirming sexual and reproductive health care, including access to culturally-competent healthcare providers; health literacy programming, to include sexual orientation, gender identity, and gender expression-based instruction and instruction on topics such as consent, relationships, and mental health; access to condoms, pre-exposure prophylaxis, contraception, abortion, and post-abortion care, and other such tools and services to effect healthful choices and self-care; and mental health care responsive to the individual needs of each young person • Ensure comprehensive training for all staff in institutions that house or detain youth to ensure they are practicing cultural humility, able to uphold the rights of all youth in their care, and adequately respond to their sexual and reproductive health care needs
Wallis (2014) No access, no choice: Foster care youth, abortion, and state removal of children	• Avoid policies that promote abstinence-only education and those that portray sex as shameful and wrong • Trust youth to make decisions about their lives and reproductive health	• Develop policies to address poverty and provide safe housing, food, education, and health care • The state must require and implement comprehensive sex education

Law review	• Promote autonomy for youth through education, support, and access to resources	
Young (2010) Promoting the sexual and reproductive health of adolescents in foster care Public health and advocacy organization	• Create cross-sector partnerships • Take time to build understanding and trust between partners • Reduce discomfort and stigma around adolescent sexuality and reproductive health by including discussion of individuals' own beliefs and attitudes in all trainings • Include youth perspectives • Use health education curricula or programs that are time-limited • Make appropriate adaptations to sexuality education curricula to ensure they meet the needs of different groups of youth, such as African Americans, Native Americans, or LGBT youth • Increase opportunities and support for youth to develop relationships with trusted adults with whom they can discuss SRH	• Provide appropriate training and technical assistance for partners, including public health professionals and child welfare professionals • Clarify the consent and confidentiality rights of minors in foster care to seek reproductive health care • Create policies to affirm that all youth be informed of their right to express their gender identity and sexual orientation • Create and implement statewide data collection systems to document SRH outcomes among YFC • Create local and state policies to ensure that YFC receive sexuality education, such as requirements to integrate sexuality education into caseworker sessions, independent living programs, and/or other youth programs