Stakeholder perceptions of strategies and barriers to sexual health discussions between foster and kinship caregivers' and foster youth: A qualitative study to inform the development of a sexual health caregiver training

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Abstract

Stakeholder perceptions of strategies and barriers to sexual health discussions between foster and kinship caregivers' and foster youth: A qualitative study to inform the development of a sexual health caregiver training

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BACKGROUND: Foster youth are more likely to contract a sexually transmitted illness (STI) and become pregnant compared to non-foster youth. The heart to heart qualitative study looked at caregiver perceptions of barriers and facilitators in talking with adolescent youth about sexual health. The data gathered has been used to caregiver focused training that will help educate and facilitate these conversations with foster youth. The purpose of this study is to learn from welfare services staff what role they serve in addition to caregivers to inform the caregiver training.

METHODS: Twenty stakeholders from a variety of occupations that work closely with foster and kinship caregivers participated in individual interviews that were conducted by telephone. Interviews were performed between October 2015 to February 2016. Participants were recruited from three different locations including New York, NY, Seattle, WA and Los Angeles, CA. stakeholders were asked semi-structured open ended questions regarding their thoughts on a caregiver's role in discussing sexual health, barriers and strategies in having these conversations and staff members' comfort level in having these discussions with foster youth. Transcripts were coded by two coders and Theoretical Thematic Analysis was conducted utilizing ATLAS.ti software.

RESULTS: Key stakeholders identified several barriers to communicating with foster youth about sexual health; in addition, strategies used to facilitate these conversations were also identified. Various themes emerged based on the description of barriers and facilitators. Most stakeholders identified caregiver beliefs and values about sex to prevent: (1) open and honest communication between caregivers and foster youth; and (2) foster youth access to accurate sexual health information and crucial medical services. Other barriers identified include staff and caregiver lack of sexual heath knowledge, youths discomfort in engaging in such conversations and the lack of mandatory training for staff and caregivers on sexual health. Many stakeholders also acknowledge that nonjudgmental communication between foster youth and caregivers, and relationship building as facilitators in having these discussions. The majority of stakeholders expressed the importance of caregivers discussing sexual health with foster youth and serving a crucial role as a point person to have these conversations.
Recommendations on content and format for caregiver training was also provided by various stakeholders.

CONCLUSIONS:

Stakeholder interviews assisted in identifying facilitators and barriers to sexual heath discussions between foster youth and caregivers. Stakeholder input provides an upstream perspective in tailoring caregiver training to decrease high risk behaviors and improve reproductive health among foster youth.

1. Introduction

Close to 428,000 children are in the foster care system on any given day, and roughly 36% are adolescents aged 11-18.[1] Foster youth are frequently exposed to abuse and neglect, and may also have been raised in environment(s) with atypical health norms and inadequate supervision. Based on previous studies conducted with foster youth and caregivers, these exposures place foster youth at risk of normalizing atypical behaviors in romantic and sexual relationships and having little guidance or modeling around healthy behaviors.[2,3] As a result, several studies have shown that foster youth have higher rates of engagement in high risk behaviors as well as negative reproductive health outcomes compared to youth in the general population including an earlier age at initial vaginal intercourse, higher rates of total and casual partners, 3-14 times increase risk for acquiring a sexually transmitted infection (STI), and 2-4 times the risk of unintended pregnancy.[4-9] Two longitudinal studies of youth transitioning out of foster care in a total of 4 states suggest that almost half of young women in foster care become pregnant before they turn 19; males are also at increased risk of impregnating a partner.[4,6] These high risk behaviors have significant implications to public health and the well being of the youth.[10-13]

The disparity in risks of sexual behaviors, pregnancies, and STIs among youth in foster care compared with other youth has prompted the creation/adaptation of programs designed to address unsafe sex practices and teenage pregnancy in this population.[14-17] These interventions have typically focused on the youth themselves and consisted of weekly sessions that address knowledge and understanding of STI and HIV transmission, condom use, contraceptive methods and communication skills.[17,18] However, it is important to note that findings as of yet have been inconclusive as to whether this approach is feasible and effective in this population. Indeed, placement instability and competing demands on youths' time to address educational, housing, mental health, and other needs may make a weekly session approach impractical for child-welfare involved youth. Further, for agencies serving primarily youth placed in single family kinship or foster homes, a lack of geographic co-location is likely

to compound feasibility challenges to a weekly in person group format. Overall, only two youth-focused interventions have been rigorously evaluated in a randomized controlled trial (RCT) among child welfare-involved youth: one did not demonstrated long-term effects,[16] and one demonstrated reduced self-reported pregnancy risk but no significant changes in STI risk or other risk behaviors.[19] Additionally, both of these interventions were delivered in group living rather than kinship or family home contexts, and although retention was high in the latter study (84% and 87% completed the whole study for intervention and control groups, respectively)[19] the former suffered from significant retention issues with only 61% completing the entire training and even fewer completing the long-term follow up assessments.[16]

Training of foster and kinship caregivers may be a promising approach to either supplement youth-focused intervention work, or as a more feasible standalone intervention to reduce pregnancy and STI risks in foster youth. Research in other populations supports this assertion; even brief, single-session caregiver-oriented interventions emphasizing communication and monitoring of youth have been shown to reduce sexual risk behaviors in other high-risk adolescent populations.[20] To the authors' knowledge, only one training has been developed for foster/kinship caregivers and caseworkers; results from a short-term pre-posttest evaluation suggested that participants had modest short-term improvements in sexual health knowledge and attitudes around talking to youth about sex.[15]

Understanding the unique barriers and facilitators to communication around sexual health may help agencies to develop trainings and other strategies to more effectively support caregivers. Our group has previously conducted studies to understand caregiver and youth experiences, barriers, and strategies to pregnancy and STI prevention among youth in the foster system.[3,21] These studies all suggest the importance and potential impact that foster and kinship caregivers can have in helping youth to make healthy choices and reduce risks of unplanned, early pregnancies and STIs. However, it is also critical to understand the perspectives of stakeholders such as social workers and administrative

staff to maximize effectiveness and feasibility of caregiver-oriented interventions. Thus, our main objective in conducting this qualitative study was to explore stakeholder perceptions of barriers and facilitators to conversations around sexual health between foster/kinship caregivers and youth, to better identify key elements needed in an effective training for agencies that would be feasible to implement in a variety of child welfare settings.

2. Methods

2.1 Sampling and recruitment procedures:

We recruited stakeholders involved in child welfare systems in the following jurisdictions: Washington State, Los Angeles County, California, and New York City, New York. The initial phase of recruitment was conducted using purposeful sampling methods, also called purposive sampling, a strategy used in qualitative research to identify participants based on specific criteria.[22] Specifically, initially we identified at least two individuals working in each of the three jurisdictions, at least one of whom had an administrative role and one of whom was involved in direct case work with foster youth and families. Study participants must have worked with foster caregivers either in the past or at time of study. We then employed a snowball sampling method to recruit additional participants and include a range of perspectives from administrators and social workers to social work managers and caregiver trainers.[22]

2.2 Interview procedure:

We received a waiver from the Washington State Institutional Review Board (IRB) and obtained either written or telephone informed consent prior to each interview. Individual interviews were performed via telephone by a single member of the research team who identifies as white and female. The interview script was created a priori and consisted of seven semi-structured open-ended questions regarding: (1) the role of stakeholders in discussing sexual health topics

with foster youth, (2) perceived barriers in having discussions; and (3) observed strategies to help facilitate sexual health conversations (Table 1). Interviews were digitally recorded, transcribed and reviewed for accuracy.

2.3 Analysis:

Once transcripts were reviewed, they were analyzed using ATLAS.ti, version 6.1 software. We used Theoretical Thematic Analysis technique, which is comprised of several phases: 1) familiarizing oneself with data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) producing the report.[23] Specifically, team members initially read and checked all transcripts for accuracy by listening to the corresponding audio file (step 1). We then created an initial codebook using core topics from the interview guide. We established inter-coder reliability by having two separate members of the research team code the first 3 transcripts and compare their coding for consistency. Once initial consistency was established, each team member was instructed to add additional codes to the codebook as indicated. Disagreements were resolved by discussion, and a second draft of the codebook was created (step 2). We then identified quotations that correlated with themes from the codebook. Each quote encompassed necessary data to provide context and allow for appropriate identification of the corresponding themes. Once transcripts were coded, we generated query reports for each topic which were reviewed by two members of the research team. Emerging and recurrent topics or general themes were brought forth and summarized into code summaries. Code summaries consisted of high level analysis of data as well as corresponding quotations. We discussed the code summaries with 4 members of the study team in person or over conference call every one to two weeks (step 3). The codebook was

reviewed for potential revisions and finalized. The research team then reviewed themes and sub themes generated from code summaries and created a thematic map to organize these themes (step 4). We then created an outline of results detailing main themes, sub themes, and exemplary quotations (step 5). Finally, two investigators, first and senior authors Serrano, J. and Ahrens, K., drafted this manuscript while simultaneously reanalyzing the data for any revisions. All co-authors reviewed and edited the manuscript as well (step 6).

3. Results

3.1 Description of participants and general roadmap of findings.

A total of 20 stakeholders from the three states participated in interviews. Of the twenty stakeholders, seven were from Seattle, eight from Los Angeles, and five from New York; see table 2 for a description of participants. The duration of stakeholder interviewers ranged from 18 to 49 minutes.

Not surprisingly based on our sampling strategy, all of stakeholders from all regions indicated that they were in support of foster and kinship caregivers having conversations with foster youth regarding sexual health. Indeed, many felt that caregivers were likely to be the most effective person to have these conversations as illustrated by this quote:

> *"[Foster and kinship caregivers] are the person that has the most contact with the youth, daily contact with the youth, and hopefully, a closer relationship, so that they can sit down and hopefully they'll have the time at home to sit and start with baby steps and plant the seeds so they can have that type of conversation with the youth so absolutely they're probably the most important person."- Social work manager, CA.*

With respect to stakeholder perspectives on barriers and facilitators to these conversations, we identified three major themes. The first theme depicted stakeholder-perceived barriers to communicating with foster youth about sexual health, such as caregiver beliefs and values about sex, cultural and generational differences between caregiver and foster youth, caregiver discomfort and lack

of knowledge, institutional factors, and characteristics of foster youth and/or their biological families that made it difficult to talk about sex. The second main theme described stakeholders' views on observed strategies to successful communication with foster youth, which included subthemes such as having the caseworker proactively identify the caregiver as the point person to carry out these discussions, and caregiver engagement in honest and direct communication, development of rapport and trust with the youth, instilling healthier norms and attitudes about sex, and having access to accurate sexual health knowledge. The final major theme consisted of stakeholder specific suggestions regarding the content and format of caregiver trainings to facilitate talking with foster youth about sexual health, for example implementation of mandatory trainings for caregivers and child welfare services staff, incorporation of opportunities to role-play and practice, development of content applicable to caregivers with a variety beliefs and values, and specific suggestions for content such as up to date information on STIs and pregnancy and guidance on the age at which sexual health discussions should be held with youth. In the paragraphs below we describe the main themes and subthemes in more detail and provide illustrative quotes. Interestingly, while the original script was focused on barriers and facilitators for foster and kinship caregivers, in many instances the themes were described as applying to child welfare staff as well. Where applicable, themes that were perceived to apply to child welfare personnel as well as caregivers are noted below.

3.2 Perceived barriers to communicating with youth

The first barrier related to caregiver beliefs and values regarding sexuality. The majority of stakeholders expressed that for some caregivers, religious beliefs were a significant barrier to successful communication with youth that frequently prevented youth from accessing information and medical services related to sexual health, as illustrated by the following quote:

> "*I had one youth…and she told me that she asked her foster mom-- she had scheduled an appointment to I think get birth control or get an IUD put in, and the foster parent was*

unwilling to provide transportation saying that it was against her religion, and that the foster youth should take the bus to the appointment if she was going to go through with it." - Mental Health Support Specialist, WA

In addition to precluding services and communication, stakeholders described that religious beliefs can marginalize lesbian, gay, bisexual, transgender, and questioning (LGBTQ) foster youth:

"I think we even have more of an issue when we're coming up with kids who are not identifying as heterosexual kids, and aren't falling in line with the religious perspective of a man and a woman kind of concept. In all of these homes, the primary route of recruiting foster parents is through churches." – Regional Office Manager, CA

Second, many stakeholders also identified non-religion based cultural and generational differences between the caregivers' view on normal adolescent sexual health behaviors and sexual health information.

"The other piece I wanted to share is that we do work with a large population of different generations, ages, and cultures. So we do have our [name of racial/ethnic group] that at times are not very open to talking about these types of things, or situations, or educating the children on sexually transmitted diseases because it's not something that was culturally acceptable to them. So sometimes some of those not having an open mind falls under culture." Foster Caregiver Coordinator, CA

A third subtheme identified by most stakeholders about barriers in caregiver communication with foster youth was a wide variation in comfort level carrying out these discussions. In Los Angeles, CA, one social worker explained:

"I think it differs from person to person. Someone may have no problem with talking about it - talk about it as if they're talking about the weather - and another person may

get knots in their stomach and probably break out in a sweats with just the thought of having such conversations with individuals." –Social Worker, CA

Lack of caregiver comfort was perceived to be multifactorial. For instance, most stakeholders described that some caregivers felt like they were giving permission for youth to engage in sexual activity by talking about sex with them.

"I think the negative might be that if they're not sexually active and it's not something that they're thinking about it might plant a seed before it needs to be there." - Mental Health Support Specialist, WA

Another area of discomfort stakeholders felt affected many caregivers related to talking about sexual and reproductive health with LGBTQ youth.

"Foster parents may not be as comfortable talking to LGBTQ youth about sexuality. Heterosexual foster parents may be uncomfortable talking to a LGBTQ kid about those issues, or may not feel like they have the information that they need to be able to open that conversation." – Administrator, Division of License Resources, Department of Social and Health Services, WA

An additional cause for discomfort that stakeholders described was the concern that these discussions could potentially re-traumatize youth and/or lead to allegations of misconduct. A social worker expressed the following:

"And here I'm thinking - we were foster parents during the Bush Administration - and so it's just very interesting how that was being taught at the Pride training for foster parents to not talk to their children about sex, because it could trigger a trauma response, and the kid could substitute the foster parent in as the victimizer, the perpetrator, and mixing up the people and so then you would put yourself at risk of being accused of being the rape person if you talked to the kid about it " –Social Worker, WA

Importantly, this theme was perceived to apply not only to caregivers, but also to caseworkers as well, as illustrated by this quote:

> *"One fear that is often expressed by social workers that I think could be applicable to just talking about sex in general, is I hear from male social workers that they are afraid that if they talk about it the youth will think that the male social worker is propositioning the youth. Which I don't know, I don't know if that is a valid concern or not. The fear of false allegations is there, absolutely, for folks." - Commercially Sexually Exploited Children's Liaison, WA*

The fourth subtheme of barriers described by majority of stakeholders included lack of knowledge about sexual and reproductive health, among foster caregivers. This was also noted among staff in child welfare services. Participants felt that lack of training or having outdated information was a deterrent to both caregivers and child welfare staff with regards to discussing sexual health topics with youth.

> *"Sometimes also I think there's kind of like a restriction on the knowledge, when it comes to the age of the foster parents. I tend to know that older foster parents tend not to have that conversation because they're not as knowledgeable. Or when they have it, it's something along the lines of like scolding their child, where it's like, 'Well, if you bring any babies in here, you won't be staying here anymore.' So I think it's like 1/3, the ones who are having the conversation, it's not being had correctly. Then you have the ones who just won't have the conversation at all." – Case Planner, NY*

The dispersion of false or inaccurate information was perceived to have directly harmful impacts on the youth, as illustrated by this example:

"The negative part about it is, let's say, if maybe the caregiver doesn't necessarily know, or has been trained, or has the knowledge about the different forms of contraception..."

– Social Work Manager, CA

The fifth subtheme related to institutional barriers to sexual health conversations. For example, a social worker from Washington State described how agency beliefs can affect the communication that occurs even at the agency level:

"You go into their offices and there is religious paraphernalia on the walls. So the message is very clear that we hold fundamental Christian values of - as a whole, that's what their philosophy is. And I think I find that when somebody has that religious value, they tend to be very, 'Save sex until marriage. And we don't talk about it. And if you've been sexually abused, we don't really talk about that either.' So I think that if you look at the subconscious messages that are coming across, it's more of a, "Don't ask, don't tell," than a, 'Let's teach our children safety.'" –Social Worker, WA

In addition, the lack of mandatory training was expressed by several stakeholders as an institutional barrier.

"Some of our foster parents, when they come, don't come with any kind of formal training. They come because they have a passion because they want to help and advocate for minors. So they're not fully aware of the scope of what an STD can do…"

Foster Caregiver Coordinator, CA

Another institutional factor identified by several stakeholders as the shortage of foster care caregivers and subsequent placement of sexual and gender minority youth with incompatible households, making it extremely difficult for these youth to receive accurate sexual health information in a supportive and affirming manner.

"Like it says, we have a shortage of foster families, so we're putting gay kids in homes where people say things like, 'Well, I mean, if he comes to live with us, we would be okay with him being gay.' That's not a home for a gay kid, right there. I can't use that home; but guess what, I have no other resources, so I have to put that kid there. And I hate that I have to do that. And if he's gay, who's going to talk to him about his sexuality? If I'm going to put him in a home where they're going to be 'fine' with him being gay. And I have so many kids who are gender-fluid right now, or questioning whether they're transgender, whether they were born into the wrong body, and there's so few resources for them to live in."- Social Worker, CA

A final subtheme regarding barriers to sexual health conversations between foster youth and caregivers include factors pertaining to the foster youth. Many participants described that youth are frequently uncomfortable talking about sex:

"I don't think most kids are comfortable talking about it in general with any adult, so I know that it's not an easy conversation to be had." –Social Worker, NY

In addition, some stakeholders also described that atypical sexual health norms in foster youth are a barrier to effective communication, as described below:

"But after this happened she was at the hospital kind of yelling at everyone and saying, 'Why am I here? This is normal. I've done this before. This is what everyone does.' So that just shows that she had no education on this, and she had been exposed to this kind of behavior so she had started to normalize it. So myself and the therapist on the case took this opportunity to really improve her education in general, and we're doing a lot of work on learning appropriate boundaries with her." –Mental Health Family Support Specialist, WA

Stakeholders also perceived that differing beliefs about sexual health discussions between the foster/kinship caregivers and the biological parent made it difficult for sexual health conversations to occur between foster youth and their substitute caregivers. This idea is illustrated below:

> *"It becomes very difficult, because we may have bio parents with a different set of values and worldview. Then it becomes very problematic when a foster parent is broaching the subject in a way that a bio parent may object to." – Administrator, Division of License Resources, Department of Social and Health Services, WA*

3.3 Perceived strategies to communicating with foster youth

Stakeholders described three strategies which they either personally utilized or saw caregivers use improved the effectiveness of conversations about sexual health with foster youth. The first was the use of open, non-judgmental communication style:

> *"It's about communicating openly. It's about telling them basically that it doesn't matter what happened, I'm going to be here for you anyways and they won't believe that at first. Something's going to have to happen. And then something will click in their brain like, 'Oh, they really do mean that.' And it's just about always communicating and then letting them know that it's safe for them to communicate no matter what it is. In our home it is." –Preschool Teacher, WA*

Stakeholders also described that deliberate relationship building also helped facilitate open and non-judgmental conversations between caregivers and foster youth. One stakeholder described doing fun activities with you in order to help build rapport:

> *"Well with any youth that I start working with, I usually spend at least a few weeks just building a rapport with them. Doing fun activities. Getting to know what they like, what their interests are, and just building a solid foundation, because without that you're not going to get any work done. That is something I definitely do with every client, and I*

think foster parents do as well. And then when I'm designing these lesson plans, I guess, I try to make them fun and engaging, and try to make it relate to the youth's interests." - Family Services Manager, LA

Finally, stakeholders also described structuring conversations to deliberately model healthy norms and attitudes around puberty sexual health, such as in this quote:

"And so of course you have to discuss the things like menstrual cycles and body odors. The whole puberty thing and whatnot. And I noticed that they were-- almost every female that we talked to was embarrassed about talking about her period like that was a really bad thing, or it was a secret thing. And so my husband and I talked about it and we said this is something that they need to understand is natural and it happens." - Preschool Teacher, WA

3.4 Stakeholder recommendations

In response to the above barriers, stakeholder provided several recommendations regarding the content and format of caregiver trainings to facilitate talking with foster youth about sexual health. For example, many stakeholders suggested mandatory trainings on discussing sexual health should be implemented for all caregivers and caseworkers, as illustrated by this quote.

"Yeah I think the training is a good place to start, but I also think working with the Department, DSHS, and making some standards that all our youth in foster care need to be provided a certain education around this. Foster parents need to provide a certain service around this" – Mental Health Family Support Specialist, WA

Stakeholders also felt that in-person trainings would be more effective than online. Participants would have the opportunity to role-play and practice, learn in a supportive environment, and facilitate answering questions.

"I like role playing too, honestly. So they get some practice with each other, have some fun with it, and I also think it would be really valuable. I think that... We have a lot of older foster parents, and they think that I'm not-- they just think they'll need to get some experience with it and be in a support group-- in a supportive environment that allows them to do that." –Health Care Director, NY

In addition, trainings should include sources of up-to-date information on STIs and pregnancy and guidance on the age at which sexual health discussions should be held with youth.

"…being able to have that conversation with kids, or at least give them proper guidance on where to find information, if not help them, next to them, to actually physically help them look up the information and become more knowledgeable about whatever their questions are, whatever their concerns are." Social Worker, NY

Table 1

Interview Script

Role of Caregivers	What are your personal thoughts about whether foster caregivers should talk to teens in foster care about preventing teen pregnancies or preventing sexually transmitted infections? What about talking specifically about safe sex, such as talking about using condoms or birth control?
	What role do you think foster caregivers should play in helping to prevent early pregnancies or STIs among teens in foster care?
	What might be the positives and negatives if a foster caregiver were to have a conversation with a foster youth about these topics?
Facilitator/Barriers	What, if any, guidance have you received from your managers or leaders regarding talking with youth about safe sex? (If necessary prompt with specific examples such as encouraging youth to wait to have sex, using condoms, or using birth control.) What guidance have you received about foster caregivers talking with youth about these topics, if any?
	How confident do you feel in your own knowledge about sexual health issues? Why do you feel that way?
	What, if any, programs are available to support foster parents in communicating about sexual health? What are some of the strengths of these programs? How about limitations?
Strategies	Our research team is developing a training for foster caregivers that will help them talk with teens about these topics. What components do you think would be most useful for a foster caregiver training like this?

Table 2

Stakeholder Characteristics

Role	Agency	Location
Social Worker	Public	CA
Foster Care Education Program, Regional Coordinator	Private	CA
Child Welfare Services Manager	Public	CA
Child Welfare Services Manager	Public	CA
Assistant Regional Administrator	Public	CA
Pregnant and Parenting Youth Facilitator	Public	CA
Social Work Supervisor	Public	CA
Foster Caregiver Coordinator	Private	CA
Foster Care Program Manager	Private	NY
Case Planner	Private	NY
Health Care Director	Private	NY
Social Work Supervisor	Private	NY
Therapeutic Foster Care Social Worker	Private	NY
Social Worker	Public	WA
WA Family Services Mental Health Clinical Director	Private	WA
WA Family Services Mental Health Support Specialist	Private	WA
Preschool teacher	Public	WA
Teaching Associate/ Social Worker	Public	WA
Commercially and Sexually Exploited Children's (CSEC) Liaison	Public	WA

Department of Social and Health Services Administrator	Public	WA

4. Discussion

Adolescents in out-of-home care, or foster care, are at higher risk for several sexual risk behaviors which results in increased risk of both STIs and early, unintended pregnancies compared to their general population counterparts.[4,5,7,8] Of the studies conducted to address this problem, few interventions have demonstrated to impact these risks[17,19] and even fewer caregiver-oriented interventions have been studied.[24] In contrast, studies in other populations have shown that caregiver trainings can reduce sexual risk behaviors.[15,20] Therefore, it is important to understand the training needs of caregivers, both from the perspectives of caregivers themselves and from other child welfare stakeholders.

The present findings are similar to but extend prior work in several ways. First, in our qualitative study with foster and kinship caregivers, participants described several communication barriers including personal discomfort in having conversations, lack of knowledge, generational, gender, and sexual orientation differences, and youth/bio family characteristics. Stakeholders in the present study echoed these barriers and indicated that they applied not only to caregivers but in many instances to child welfare agency personnel as well. They also emphasized the potential importance of culture and religion, two barrier-related themes that were not prominent in our prior work with foster caregivers.

Second, both caregivers and stakeholders identified the perceived risk of an allegation of misconduct if/when caregivers talked to youth about sex as a critical barrier to these conversations, due to concerns that the conversations might be misinterpreted, trigger trauma symptoms, or give youth permission to have sex. Participants in both studies recommended clear communication from agencies in the form of policies and/or laws in support of sexual health conversations between youth and caregivers. Nationally, data support this recommendation: while it is important when working with youth who have trauma histories to be sensitive to potential triggers and conduct conversations in a trauma-informed manner,[2,25,26] youth with maltreatment histories are at higher risk of early, unintended

pregnancies and STIs, and therefore should not be denied access to straightforward, non-judgmental information about sexual health.[27,28]

Third, both caregivers and stakeholders identified open, honest and nonjudgmental communication about sexual health as important facilitators in carrying out productive discussions.

The majority of stakeholders also shared that they felt sexual health trainings should be mandatory for both foster and kinship caregivers as well as child welfare staff. In all 3 jurisdictions included in this study, trainings on for caregivers talking with youth about sexual health were described at worst to be non-existent and at best to be voluntary (and therefore likely attended by individuals with a higher baseline comfort level in having these discussions). Although one jurisdiction made training mandatory for caseworkers (LA County), most child welfare systems to not require sexual health training for agency staff either. Mandated training sessions for both caregivers agency would potentially help to eliminate selection bias that occurs in attendance at trainings about sexual health.

There were several limitations to our study. First, we interviewed stakeholders from larger urban cities (e.g., New York City, NY, Los Angeles, CA, and Seattle, WA); therefore findings may not be applicable to all child welfare jurisdictions such as more rural areas and/or or agencies in more politically conservative environments. In addition, by virtue of the fact that they were willing to discuss their viewpoint in this study, our stakeholders participated may have had a higher comfort level at baseline thus contributing to selection bias. However, collectively they still provided an important perspective on barriers and facilitators to conversations about sexual health. Finally, our study had a small sample size, however it should be noted that an N of 20 is typical for a qualitative study.

In conclusion, stakeholders in our study viewed conversations between caregiver and foster youth as essential, but also identified several barriers to these conversations. Clear guidance from child welfare agencies and caregiver-oriented trainings that include straightforward information and skill-building strategies could help to mitigate these barriers.

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