Children and Youth Services Review 88 (2018) 434–440

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Stakeholder perceptions of barriers and facilitators to sexual health discussions between foster and kinship caregivers and youth in foster care: A qualitative study

Jessica Serrano[a,b,*], Julia M. Crouch[a], Katie Albertson[a], Kym R. Ahrens[a,b]

[a] Seattle Children's Research Institute, Center for Child Health, Behavior and Development, 2001 8th Ave, M/S CW8-6, Seattle, WA 98121, USA
[b] University of Washington, 1410 NE Campus Parkway, Seattle, WA 98195, USA

ABSTRACT

Purpose: Youth in foster care are more likely to contract a sexually transmitted infection (STI) and become pregnant than other youth, who have not been in foster care. This study explored stakeholder perceptions of barriers and facilitators to conversations about sexual health between foster/kinship caregivers and youth in foster care, with the goal of developing a brief, scalable sexual health training for caregivers.

Methods: We conducted individual phone interviews with twenty stakeholders from a variety of occupations that work closely with foster and kinship caregivers in 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 facilitators in having these conversations, and staff members' comfort level in having these discussions with youth in foster care. We coded and analyzed transcripts using Thematic Analysis technique.

Results: Themes emerged around three main categories: 1) barriers to sexual health conversations with youth in their care, including caregivers' religious and personal beliefs impeding youth access to accurate sexual health information and crucial medical services, staff and caregiver lack of sexual heath knowledge, caregiver and/or youth discomfort in engaging in sexual health conversations, and a lack of mandatory training for caregivers and staff on sexual health; 2) facilitators to sexual health conversations with youth, including open and nonjudgmental communication between youth in foster care and caregivers, and engagement in deliberate relationship-building activities with the youth; and 3) recommendations for content and format of a training for caregivers and agency staff to address barriers to conversations, such as making trainings mandatory and in-person.

Conclusions: Stakeholders identified several barriers and facilitators to sexual health conversations and viewed conversations between caregiver and the youth in foster care as essential to the youth's wellbeing. Clear guidance from child welfare agencies and caregiver-oriented trainings that include straightforward information and skill-building strategies could help to mitigate these barriers and related health disparities.

1. Introduction

1.1. Sexual health among adolescents and young adults

Sexually transmitted infections (STIs) are a critical public health concern for adolescents. Youth and young adults aged 15–24 have the highest risk of contracting STIs and account for almost half of all new reported cases of STIs (Satterwhite et al., 2013). In 2016, approximately one million adolescents and young adults reported having a chlamydia infection and there were 460,000 new cases of gonorrhea (Centers for Disease Control and Prevention, 2017). Medical care costs associated with STIs were roughly $16 billion (Owusu-Edusei et al., 2013).

Similarly, teen pregnancy is an impactful outcome associated with significant economic and educational costs. Although rates are declining, in 2015 almost 230,000 births were from women aged 15–19, with one in five being a repeat birth (Martin, Hamilton, & Osterman, 2017; Schelar, Franzetta, & Manlove, 2007). Teen births have several effects on educational attainment, financial costs and perinatal outcomes. Data indicates that only one third of teen moms who give birth before age 18 will obtain their high school diploma before age 19 (Perper, Peterson, & Manlove, 2010). Data from 2010 and 14 years prior indicated that taxpayers spent $9.4 billion in services associated

* Corresponding author at: CDRCP-Office 2206, 707 S.W. Gaines Street, Portland, OR 97239, USA.
E-mail addresses: serranoj@ohsu.edu (J. Serrano), julia.crouch@seattlechildrens.org (J.M. Crouch), katie.albertson@seattlechildrens.org (K. Albertson), kym.ahrens@seattlecildrens.org (K.R. Ahrens).

https://doi.org/10.1016/j.childyouth.2018.03.020
Received 4 July 2017; Received in revised form 10 March 2018; Accepted 10 March 2018
Available online 12 March 2018

with teen childbearing (Power to Decide, 2013). Additionally, newborns born to teen mothers are more likely to be born preterm, to be low birth weight, and to be born stillbirth (G. C. Smith & Pell, 2001; Torvie, Callegari, Schiff, & Debiec, 2015; Wilson, Alio, Kirby, & Salihu, 2008).

1.2. Parental role in adolescent sexual behavior

In a survey of 1000 adolescent females, almost 90% felt that open and honest conversations with a parent would facilitate the delay of sexual debut and preventing pregnancy (Power to Decide, 2015). Observational studies with parents have confirmed these findings: for example, in a study conducted by DiClemente et al. (2001), less communication between parent and adolescent was associated with decreased use of contraceptives and condom use (Aspy et al., 2006; Dilorio, Kelley, & Hockenberry-Eaton, 1999; Whitaker, Miller, May, & Levin, 1999). Similarly, several interventions tailored to improve parent-child communication have shown an increase in condom use, self-efficacy to refuse pressure to have sex, and knowledge of STIs (Dancy, Crittenden, & Talashek, 2006; Dilorio et al., 2006; Dilorio, McCarty, Reznicow, Lehr, & Denzmore, 2007; Lederman, Chan, & Roberts-Gray, 2008; Prado et al., 2007; Stanton et al., 2004).

1.3. Sexual health among adolescents and young adults in foster care

There are approximately 437,000 children in the foster care system in the U.S., and roughly 35% of those youth are adolescents aged 11–18 (U.S. Department of Health and Human Services et al., 2017). Compared to youth in the general population, youth in foster care have higher rates of both STIs and early pregnancies, likely due to the effects of trauma or a lack of guidance or modeling around healthy behaviors. Specifically, they are 3 to 14 times likelier to acquire STIs (Ahrens et al., 2010). Two longitudinal studies of youth from four different states who were transitioning out of foster care suggest that youth in foster care are also two to four times likelier than their peers to have an unintended pregnancy: almost half of young women in foster care become pregnant before they turn 19 as opposed to 20% of young women in the general population; male youth in foster care were also more likely to impregnate a partner (Courtney et al., 2005; Courtney et al., 2016). Youth in foster care have higher rates of engagement in high risk behaviors, including an earlier age at sexual debut and a higher number of total and casual partners (Ahrens et al., 2010; Ahrens, Spencer, Bonnar, Coatney, & Hall, 2016; Carpenter, Clyman, Davidson, & Steiner, 2001; Courtney et al., 2005; Courtney, Terao, & Bost, 2004). These outcomes and related behaviors have significant costs and implications both for the wellbeing of youth in foster care and for public health (Ahrens, Garrison, & Courtney, 2014; Cates, Herndon, Schulz, & Darroch, 2004; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Tyler & Melander, 2010).

1.4. Foster care-specific programs

The disparity in risks of engaging in sexual behavior, pregnancies, and STIs among youth in foster care compared with other youth has prompted the creation and adaptation of programs designed to address unsafe sex practices and teenage pregnancy in this population (Becker & Barth, 2000; Boustani, Frazier, & Lesperance, 2017; Dworsky & Dasgupta, 2014; Slonim-Nevo, Auslander, Ozawa, & Jung, 1996; T. Smith, Clark, & Nigg, 2015). These interventions have typically focused solely on youth and consisted of sessions that address knowledge and understanding of STIs and HIV transmission, condom use, contraceptive methods, and communication skills. However, it is important to note that findings have been inconclusive as to whether this approach is feasible and effective in this population for several reasons, including placement instability and competing demands on youths' time to address educational, housing, mental health, and other needs. Furthermore, for agencies serving primarily youth placed in single family kinship or foster homes, a lack of geographic co-location is likely to compound challenges to a weekly in-person group format. Overall, only two youth-focused interventions have been rigorously evaluated in a randomized controlled trial among child welfare-involved youth—one did not demonstrate long-term effects (Slonim-Nevo et al., 1996), and one demonstrated reduced self-reported pregnancy risk, but no significant changes in STI risk or other risk behaviors (Covington et al., 2016). Additionally, both of these interventions were delivered in group living rather than kinship or family home contexts. The former suffered from significant retention issues with only 61% completing the entire training and even fewer completing the long-term follow up assessments.

Training of foster and kinship caregivers, rather than just youth, may be a promising approach, either as a supplement to youth-focused intervention work, or as a more achievable standalone intervention to reduce unintended pregnancy and STIs in youth in foster care. 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 (Stanton et al., 2004).

To the authors' knowledge, only one evidence-based 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 (Dworsky & Dasgupta, 2014). In prior work done in a qualitative study with foster and kinship caregivers, caregiver participants described several barriers to communication, including personal discomfort with having conversations about sex, lack of sexual health knowledge, generational, gender, and sexual orientation differences, and youth and biological family characteristics which may limit their ability to communicate effectively (Albertson et al., 2017).

1.5. Current study

Studies described in the previous sections suggest the importance and potential impact that foster and kinship caregivers can have in helping youth to make healthy choices and thus reduce unintended pregnancies and STIs; and provide information regarding the barriers that foster and kinships caregivers face, from the perspectives of the caregivers themselves (Aspy et al., 2006; Dilorio et al., 1999; Dworsky & Dasgupta, 2014; Whitaker et al., 1999). However, it is also critical to understand the perspectives of stakeholders, such as social workers and administrators, to maximize effectiveness and feasibility of caregiver-oriented interventions. Understanding the unique barriers and facilitators to communication around sexual health may help social services agencies to develop trainings and other resources to more effectively support caregivers. Thus, our main objective in conducting this qualitative study was to explore stakeholder perceptions of barriers and facilitators to conversations around sexual health between caregivers and youth in foster care, and to identify key elements of an effective training agencies would be able 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: King County in Washington, Los Angeles County in California, and New York City in New York. We recruited using purposeful sampling methods, also called purposive sampling, a strategy used in qualitative research to identify participants based on specific criteria (Miles & Huberman, 1994). In each jurisdiction, we recruited at least one stakeholder with an administrative role and one