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Sexual and Reproductive Healthy Policies for Foster Youth: An examination of the content and context of practices in California

By

Janine Suzanne Bruce

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Public Health

in the

Graduate Division of the

University of California, Berkeley

Committee in charge:

Professor Joan Bloom, Chair

Professor Ann Keller

Professor Jill Duerr Berrick

Spring 2013

Sexual and Reproductive Healthy Policies for Foster Youth: An examination of the content and context of policies and practices in California

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By Janine Suzanne Bruce

ABSTRACT

Sexual and Reproductive Healthy Policies for Foster Youth: An examination of the content and context of practices in California

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Janine Suzanne Bruce

Doctor of Public Health

University of California, Berkeley

Professor Joan Bloom, Chair

Background

Foster care children and youth are among the most vulnerable populations in the U.S. (Farruggia & Sorkin, 2009). Foster youth are at particularly high risk for sexual risk taking, adolescent pregnancy, and early childbearing (Carpenter et al., 2001; Courtney & Dworsky, 2006; Dworsky & Courtney, 2010; James et al., 2009; Risley-Curtiss, 1997). They lack connections to trusted and knowledgeable adults with whom they can discuss sexual health issues (Constantine et al., 2009; Haight et al., 2009; Love et al., 2005). Studies with child welfare staff, foster parents and caregivers, and foster youth increasingly suggest the importance of establishing clear and consistent policies and procedures (Boonstra, 2011; Collins et al., 2007; Constantine et al., 2009; Love et al., 2005). The applicability and feasibility of such policies has not been documented in the literature. The present study examines the content and context of sexual and reproductive health policies for foster youth in California to assess the potential applicability of policy implementation across the state.

Methods

Santa Clara County case study of policy formation and implementation: An in-depth case study of the policy formation process and history, implementation status and policy stakeholder experiences was conducted in Santa Clara County (SCC), a county with a known sexual and reproductive health policy for foster youth. Key informant interviews were conducted with county experts knowledgeable about health and social policies related to foster youth sexual and reproductive health. Snowball sampling was used to maximize the range of key perspectives and specialties. A theoretical framework for the policymaking was used to examine policy formation and implementation. A total of nine individuals participated in the interviews, representing six agencies and organizations. Supplemental documents relevant to the policy process were obtained from study participants and qualitatively analyzed along with the expert interviews.

Statewide assessment of existing policies and procedures: Child welfare professionals from a sample of counties participated in a web-based survey to assess current policies and procedures, and in brief expert interviews to examine policy practices. A document review of publically available policy documents was conducted for the sampled counties to identify and examine

existing policies and procedures. Representatives from 17 counties participated in the survey and interviews; two formal policy documents were reviewed and summarized.

Qualitative analysis: Qualitative analysis was conducted using NVivo© software to input, organize and code data. Manual transcript-based theme analysis was subsequently conducted, using a process of inductive highlighting and coding of relevant themes for each broad topic area or general theme (Bertrand et al., 1992; Fonteyn et al., 2008; Krueger, 1994), and exemplary quotes identified.

Results

Santa Clara County case study

Participating stakeholders recognized the key issues and implications of early pregnancy and childbearing among foster youth. Stakeholders also identified attainable solutions to address youth needs. Solutions included 1) the judges' roles as leaders and conveners, 2) the active involvement of multiple stakeholders in developing and implementing a sexual and reproductive health policy for youth, and 3) the central role of child welfare staff and social workers in addressing the sexual and reproductive health issues and needs of foster youth. Finally, the political conditions were primed for addressing this issue as demonstrated by the involvement of key national organizations in increasing awareness about the unique needs of court involved youth and highlighting the unique role of juvenile court judges. The juvenile court judges functioned as highly influential policy entrepreneurs involved in the policy process. They brought legitimacy to this issue, and helped push this issue to a local policy agenda.

The implementation activities described in this case study demonstrate key aspects of both the top-down bottom-up approaches to policy implementation (Hjern, 1982; Sabatier, 1986). The early implementation process denotes strong top-down influence, as policy decision makers were influential in developing and mandating adherence to a new policy for foster youth. However, the implementation process described in this case study largely demonstrates a bottom-up approach. There was wide discretion in terms of how individual social workers interpreted and carried out the policy mandates, and there were no established measures to monitor and assess implementation.

Statewide assessment

This assessment demonstrates that while child health professionals are aware of multiple sources of information, support and services for foster youth, few counties have formal policies and procedures outlining and mandating the resources that youth receive. Referrals to external services and support and conversations with social workers were the most commonly cited resource for providing youth with sexual and reproductive health information. Several study participants noted that resources for foster youth are delivered on a case-by-case basis.

Across counties, there was widespread recognition that the issues associated with youth sexual and reproductive health were significant and problematic for youth and child welfare staff. Social workers were perceived to be uncomfortable and inadequately training to address these issues with foster youth. Possible identified policy solutions included: 1) collaborative partnerships with public health nurses to deliver resources and support to both youth and social workers; and 2) use of social workers from specialized adolescents units to address these needs. However, the presence of collaborations with public health nurses and specialized adolescent units were cited

by few counties; leaving most counties to rely on optional and periodic involvement in ILP workshops, and infrequent and inconsistent discussions with social workers.

Several study participants cited the need for child welfare administrators to prioritize and mandate that social workers address youths' sexual and reproductive health needs. Given competing mandates and numerous work force demands, some child welfare staff believed that it would be difficult to make this a priority without administrative mandates. Furthermore, most study participants believed that the youth, social workers and foster parents/caregivers in their county would benefit from a formal policy. Nonetheless, policy formation had only occurred in one of the sampled counties (Los Angeles). The missing policy element may have been an unsuitable political context. Only two counties cited conditions or factors indicative of political support; involvement and influence from external advocacy organizations in raising awareness about foster youths' sexual and reproductive health needs.

Conclusion

The Santa Clara County (SCC) case study demonstrates the feasibility of policy reform given the presence and alignment of necessary policy streams. The policy process in SCC suggests the importance of sufficient problem recognition, identification of feasible policy solutions, and an amenable political environment. Two juvenile justice judges functioned as influential policy entrepreneurs, effectively bringing greater prioritization to this issue and promoting agenda setting. While the juvenile judges were key actors in the SCC policy process, there is evidence from the statewide assessment that actors from other policy venues can be influential in establishing problem definition and promoting agenda setting. However, this case study shows that formal policies cannot, by themselves, produce changes at the street level and that the implementation process is not easy and needs to be supported with ample resources and involvement of committed stakeholders. These findings are supported by the implementation literature that proposes that policy change is only a necessary first step in a longer process of creating new roles and practices.

However, the question remains as to whether or not policy formation is sufficient solution given the lack of evidence demonstrating the success policy implementation and a substantive impact on youth outcomes. Though there is evidence from this study indicating that child welfare staff need a policy mandate to change current practices, additional evidence is needed to substantiate the content of these policies and the degree to which they should be implemented across various county settings. As such, it is necessary to develop comprehensive data tracking and monitoring systems that will provide a greater understanding of the scope of unplanned pregnancies, live births, parenting, adoptions, abortions, and sexually transmitted infections among young women and men in foster care. The availability of outcome data also has the potential to provide additional evidence and new problem framing around this issue that can be helpful to future policy entrepreneurs interested in promoting agenda setting and policy change. Additionally, without such established monitoring systems it will be difficult for county stakeholders to critically assess youth needs, and evaluate the impact of specific policies and procedures.

DEDICATION

To Ian and Colin Bruce, for your love, support and encouragement.

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CHAPTER 1: Introduction

Foster care children and youth are among the most vulnerable populations in the U.S. As a result of the multiple problems that these children encounter in their original families, and as a consequence of their experiences in the child welfare system (e.g. frequent placement changes, duration in the foster care system) *(Farruggia & Sorkin, 2009)*, foster care children and youth are at a particularly high risk for a host of physical and mental health problems *(Jee et al., 2008)*. Children and youth in foster care are also more likely to be involved in health compromising behaviors *(Farruggia & Sorkin, 2009; Gramkowski et al., 2009)*, which puts them at additional risk for sexual risk taking, adolescent pregnancy, and early childbearing *(Carpenter et al., 2001; Courtney & Dworsky, 2006; Dworsky & Courtney, 2010; James et al., 2009; Risley-Curtiss, 1997)*.

The foster youth population is distinct from the general adolescent population in the U.S. in terms of risk taking behaviors, access to sex education, motivations for pregnancy and childbearing, and connections to trusted and knowledgeable adults with whom they can discuss sexual health issues *(Constantine et al., 2009; Haight et al., 2009; Love et al., 2005)*. The consequences of early childbearing for foster youth differ from their adolescent counterparts not in foster care. Most notably, young parents in foster care may not have the physical and emotional support, and safety net to effectively cope with a teen birth *(Svoboda et al., 2012)*, which places their children at increased risk for abuse, neglect, and possible placement in foster care. While it is impossible to discount the potential for positive outcomes associated with early childbearing for foster youth, it is clear that they are a unique and vulnerable population that needs special consideration with respect to the promotion of healthy sexual and reproductive health.

What should be done to address the sexual and reproductive health needs of foster youth? There is no shortage of promising interventions aimed at reducing sexual risk-taking and preventing potentially negative sexual outcomes among adolescents. Many program evaluations boast positive effects; however, few offer credible evidence regarding the effectiveness of these programs due to significant design and methodological flaws *(Constantine, 2008)*. Two meta-analyses of intervention studies aimed at 1) reducing pregnancy-related outcomes among adolescents (Campbell Systematic Review) *(Scher et al., 2006)*, and 2) preventing unintended pregnancies among adolescents (Cochrane Collaboration) *(Oringanje et al., 2009)* demonstrate limited evidence of the impact of most interventions. However, the Campbell Review demonstrates promising results associated with intensive multi-component youth development programs serving higher risk adolescents *(Scher et al., 2006)*. Youth development programs strive to build strengths, skills, and possibilities among youth *(Benson et al., 2006)* while promoting the development of assets and protective factors that provide insulation from engagement in problem behaviors *(Catalano et al., 2010; Sesma Jr. & Roehlkepartain, 2003; Smith & Barker, 2009)*. Though youth development programs have demonstrated success in altering behaviors and impacting outcomes *(Philliber et al., 2002; Scher et al., 2006)*, they often require a significant human and financial investment that limits large-scale implementation. Additionally, these programs demonstrate success among general adolescent populations, and may not account for the unique needs of adolescents in foster care. Presently, few programs

specially designed for the foster youth population have been developed and rigorously evaluated *(Constantine et al., 2009)*.

Foster youth experience incomplete and haphazard sources of sexual and reproductive health information. These include county-based independent living programs (ILP), school-based sexuality education classes, medical providers, community resources, and unstructured discussions with social workers and caregivers. While these programs and individuals provide sexual health information to youth there are multiple barriers preventing youth from accessing available information, services and support. Child welfare providers and foster parents are another potential source of information and support for youth. Unfortunately, many of these individuals believe they are unprepared to talk to youth about these issues, citing lack of training as a major barrier *(Constantine et al., 2009; Love et al., 2005)*. Foster parents/caregivers, in particular, also believe that they are ill-equipped to initiate conversations with youth, leaving many youth feeling uncomfortable and unable to approach them with questions and concerns about sexual health issues *(Love et al., 2005)*.

Studies with child welfare staff, foster parents and caregivers, and foster youth increasingly suggest the importance of establishing clear and consistent policies and procedures to outline the role and responsibilities of social workers and clarify issues of liability, parental rights, and youth rights to privacy and confidentiality. From the perspectives of these stakeholders, the policies and procedures will clarify roles and responsibilities, and also stipulate needed training to help facilitate discussions between youth, child welfare staff and/or caregivers *(Boonstra, 2011; Collins et al., 2007; Constantine et al., 2009; Haight et al., 2009; Love et al., 2005)*. The applicability and feasibility of such policies is not documented in the literature. Prior to engaging in large-scale policy formation, it is necessary to examine the content, context, and potential influence of policies among policy stakeholders. Without such an examination of the context for which policies will be developed, wide spread policy implementation may be premature.

The present study seeks to examine the content and context of sexual and reproductive health policies for foster youth in California. The present study seeks to 1) examine the policy formation process and history, implementation status and policy stakeholder experiences for a selected county with a known sexual and reproductive health policy; 2) identify county procedures in California related to foster youth sexual and reproductive health needs, rights, services, and education across a sample of California counties with and without policies; and 3) explore the key issues relevant to county-level policy formation among the sampled counties to determine how these issues are or are not consistent with those identified in policy history of the county with the known policy.

The examination of county procedures related to foster youth sexual and reproductive health needs, rights, services, and education across a sample of counties will help identify possible similarities, variations, and gaps in information, services and support. The policy story and lessons learned from the case study of the county with a known policy, along with the exploration of key issues relevant to county-level policy formation among counties with and without policies, will help to better understand the relevance and applicability of policies across counties with varying policy environments.

CHAPTER 2: Background

Foster children and youth

Child neglect and abuse is a pervasive problem in the U.S. that cannot be ignored. In 2010, the U.S. Department of Health and Human Services Children's Bureau reported that more than 5.9 million children nationwide were subjects of investigations or assessments through Child Protective Services. An astonishing 695,000 children were found to be victims of maltreatment. These young victims suffered from neglect (78.3%), physcial abuse (17.6%), and sexual abuse (9.2%), with some children experiencing multiple forms of maltreatment *(U.S. Department of Health and Human Services et al., 2011)*.

The U.S. child welfare system is charged with protecting abused and neglected children in this country *(Schneiderman, 2005)*. Child Protective Services (CPS) agencies throughout the country respond to concerns about child abuse and neglect, and many of the most vulnerable children are placed in out-of-home care (foster care, kinship care, treatment foster care, and residential and group care) when it has been determined that their parents are unwilling or unable to care for them safely, or because their health and safety are at imminent risk. By the time children are removed from their home environment, they have likely experienced multiple traumatic events such as unstable living conditions, contact with an impaired parent, exposure to violence, maltreatment, neglect and abandonment *(Farruggia & Sorkin, 2009; Jee et al., 2008)*. For the purposes of this study, foster care will encompass the out-of-home care population, i.e. children and youth that have been removed from their biological families.

Foster care children and youth are among the most vulnerable populations in the U.S. As reported by the Adoption and Foster Care Analysis Reporting System (AFCARS) 408,425 children were living in out-of-home placements in 2010 *(U.S. Department of Health and Human Services et al., 2010)*. Approximately 32% of children in foster care are adolescents of reproductive age (14-20 years) *(Svoboda et al., 2012)*. While placement in foster care is intended to be temporary, the average length of stay is 26.7 months. In 2009, 11% (48,088) of the children in foster care had been in the foster care system for over five years *(U.S. Department of Health and Human Services et al., 2010)*. Additionally, many youth enter out-of-home care while they are under juvenile court supervision due to behavioral problems in the home *(Barth et al., 2006)*.

Physical and mental health of foster youth

As a result of the multiple problems that these children encounter in their original families, and as a consequence of their experiences in the child welfare system (e.g. frequent placement changes, duration in the foster care system) *(Farruggia & Sorkin, 2009)*, foster care children and youth are at particularly high risk for physical and mental health problems *(Jee et al., 2008)*. Children and youth who have been exposed to abuse and neglect experience increased behavioral and mental health issues including emotional dysregulation, insecure attachment behaviors *(Jee et al., 2008)*, anxiety, post-traumatic stress disorder, and depression *(Kools & Kennedy, 2003;*

Leslie et al., 2005; Massinga & Pecora, 2004; Pilowsky, 1995; Sawyer et al., 2007; Stirling & Amaya-Jackson, 2008).

Many children also enter the system with physical health problems directly resulting from the neglect and trauma that they experienced prior to placement *(Chernoff et al., 1994; Halfon et al., 1992; Hansen et al., 2004)*. It has been estimated that one in two youth in foster care have a chronic medical condition unrelated to behavioral issues *(Diaz et al., 2004)*. To make matters worse, many children entering foster care are low utilizers of the health care system, and are thus not getting their health care needs met *(Risley-Curtiss et al., 1996)*. Children and youth in foster care are also more likely to be involved in health compromising behaviors *(Farruggia & Sorkin, 2009; Gramkowski et al., 2009)*, putting them at additional risk for sexual risk taking, adolescent pregnancy, and early childbearing *(Carpenter et al., 2001; Dworsky & Courtney, 2010; James et al., 2009; Risley-Curtiss, 1997)*. Finally, long term consequences of placement in foster care include an increase risk of homelessness as adults *(Koegel et al., 1995)*, which may place them at increased risk for a host of associated physical and mental health issues related to their homelessness.

Sexual health risks among foster youth

Foster care is associated with early sexual activity *(James et al., 2009)*, STI's *(Risley-Curtiss, 1997)*, greater number of sexual partners, and early pregnancy *(Carpenter et al., 2001; Courtney & Dworsky, 2006; James et al., 2009; Leslie et al., 2010; Risley-Curtiss, 1997)*. A survey of foster care agencies in New York City (2005) found that 16% of female foster youth aged 13-21 years were either pregnant (4%) or parenting (12%) *(Gotbaum et al., 2005)*. A 13 state study of foster youth estimated that 17% of the young women served by Casey Family Programs (private agency serving foster youth) had given birth to at least one child while in foster care from 1966-1998 *(Pecora et al., 2003)*. A more recent survey of 732 foster youth (2002-2004) in Illinois, Iowa, and Wisconsin (Midwest Study) found that 32.9% of young women in foster care had ever been pregnant by age 17 or 18, compared to only 13.5% of their adolescent counterparts not in foster care from the National Longitudinal Study of Adolescent Health (*Add Health*). By age 19 years, this gap widened. Half of the foster youth (50.6%) had ever been pregnant, compared to only 20.1% of the *Add Health* group. By age 19, repeat pregnancies were also more common among foster youth, as compared to youth not in foster care (46.4% vs. 33.9% respectively). Additionally, 22% of female foster youth ages 17 and 18 years, and 35% of those 19 years old had "definitely" or "probably wanted" to become pregnant *(Dworsky & Courtney, 2010)*.

A recent review by Svoboda et al (2012) examines peer-reviewed journals and non-peer reviewed reports (white papers) from 1989 to 2010. Over the 20-year period, study authors found only 16 studies examining pregnancy and/or parenting among foster youth, highlighting the shortage of studies critically examining this issue. Rates of adolescent pregnancy and childbearing among foster youth are not clear and vary considerably across studies and populations of foster youth studied. Some findings are based on small or specific populations of foster youth, while others do not have a sufficient comparison group from which to compare sexual and reproductive health outcomes. Despite the paucity of data and the shortcomings associated with the designs and methodologies used, the data show that foster youth are at increased risk for pregnancy, repeat pregnancies, and early childbearing *(Svoboda et al., 2012)*.

There are, however, inconsistencies with respect to the sexual behaviors of foster youth. For example, the Midwest Study shows that sexually experienced female foster care youth had comparable contraceptive use at last sex as their counterparts from the *Add Health* study (65% for both groups). By age 17 years, foster youth are more likely to have received family planning services (15% and 7.5% respectively). Despite these promising behaviors while in care, the survey also found greater non-use of contraception among both teen boys and girls who have exited the child welfare system (15% out of care; 9% in care) *(Bilaver & Courtney, 2006; Courtney & Dworsky, 2006)*. In other words, access to information and contraception does not always mean that youth will consistently use prevention methods *(James et al., 2009)*. A qualitative study with foster youth found that some youth feel a sense of invincibility with respect to the consequences of sex, while others distrust the effectiveness of contraceptives. The study noted that some of the distrust stems from misunderstandings of how contraceptives work. Furthermore, the quality and content of information that youth receive may be too little and/or too late to have an appreciable impact *(Love et al., 2005)*. These data demonstrate logistical, attitudinal, and other barriers beyond access that prevent foster youth from seeking services and taking necessary steps to protect themselves *(Constantine et al., 2009)*.

The above challenges are heightened by the relative lack of access for foster youth to necessary and standard sources of reproductive health information, services, and support. For example, many foster youth obtain sex education through the county independent living program (ILP) classes. The challenge, however, is that not all foster youth are eligible or able to participate in ILP sexual and reproductive health workshops. Another potential source of information is through school-based sexuality education classes. Foster youth often miss out on school-based information for a number of reasons including fragmented, incomplete, ineffective or simply non-existent curricula, or due to placement instability. Additionally, some foster parents and caregivers may not allow the youth to participate due to ideological or logistical reasons *(Goldfarb & Constantine, 2011)*. Child welfare staff are another potential source of information and support for youth. Unfortunately, many child welfare workers feel unprepared to talk to youth about sex and contraception, and cite lack of training as a major barrier. Foster parents/caregivers also feel ill equipped to initiate conversations with youth, leaving many youth feeling uncomfortable and unable to approach them with questions and concerns about sexual health issues. These barriers are further heightened by a lack of pregnancy prevention protocols and policies that clearly outline roles and responsibilities for individuals who support and parent youth *(Constantine et al., 2009; Love et al., 2005)*.

Another prevention challenge is that foster care youth experience strong pressure from their peers to have sex. Adolescent pregnancy is often largely accepted by youths' peers and also by one's family of origin. Some youth see great benefits associated with early childbearing, such as the desire to have someone to love and be loved by *(Constantine et al., 2009)* and a family of their own *(Love et al., 2005)*. Becoming pregnant and having a child can also be viewed as a way to hold on to a partner *(Constantine et al., 2009)*, which fulfills a need to have someone who won't leave them. Additionally, some youth feel that having a child will bring greater purpose to their lives *(Pryce & Samuels, 2010)* and provide their only way out of a harmful lifestyle—an opportunity to get their lives on track *(Haight et al., 2009; Love et al., 2005)*.

Foster youth express a desire for consistent and enduring relationships with caring adults with whom they can discuss love, sex, and relationships *(Constantine et al., 2009; James et al., 2009)*. Meanwhile, strong relationships between adolescents and their parents have been found to be

critical in the prevention of teenage pregnancy and other risky behaviors *(Blum & Rinehard, 1998)*. Unfortunately, frequent placement changes make it difficult for foster youth to develop critical relationships with foster parents, caseworkers *(Love et al., 2005)*, and other important adults with whom they can build relationships and discuss how to prevent unplanned pregnancies *(James et al., 2009)*. Personal relationships are particularly important for these youth, as placement in foster care puts them at increased risk for interpersonal disconnection, which often manifests itself in the form of protective distancing from others, maintaining a defensive posture and/or keeping relationships superficial. While youth employ these mechanisms to protect themselves from further disappointment, rejection, trauma, and losses associated with multiple placements and transitions *(Kools et al., 2009)*, doing so leaves them without the social support networks they need to support healthy sexual and reproductive health. Early pregnancy and childbearing is potentially harmful for foster youth, as these youth are less likely to have the support mechanisms to help make important decisions and care for a child.

Placement for parenting foster youth is a challenge for child welfare workers charged with finding placements for both the youth and the child. A 1995 study through the Youth Advocacy Center documented a shortage of group homes and trained foster parents that are able to address the needs of parenting youth. In some cases this results in separation of the infant and young mother following birth, as appropriate teen parent and child placements are sought *(Krebs & de Castro, 1995)*. Pregnant and parenting foster youth also experience challenges accessing other necessary support services, *(Gotbaum et al., 2005)* such as child care and parenting skills *(Collins et al., 2007)*. Proper placements for young parents in foster care and their children is essential for adequately supporting and preserving these young families.

The children of minor parents in foster care face their own challenges and obstacles within the child welfare system. An Illinois study examining the unique needs of over 4,000 pregnant and parenting youth in foster care found that 22% of mothers were investigated for child abuse or neglect, and 11% of mothers had children placed in foster care *(Dworsky & DeCoursey, 2009)*. Early childbearing has the potential to disrupt the critical normative psychological processes that occur during adolescence for all young parents who must deal with the demands and responsibilities associated with parenthood *(Coley & Chase-Lansdale, 1998)*. As mentioned above, young parents in foster care do not always have the physical and emotional support, placement opportunities, and safety net to effectively cope with a teen birth, which places their children at increased risk for abuse, neglect, and possible placement in foster care *(Gotbaum et al., 2005)*.

Another significant challenge is the status of children born to parents in foster care. As is the case in California and New York, these children are not considered to be in the foster care system with their parents unless they are found to be abused or neglected *(Gotbaum et al., 2005)*. This makes them ineligible for social welfare support, creating a financial burden on young parents and their foster families that exacerbates their situation. Lack of support and financial hardships can force teen foster parents to leave their placement, which may result in subsequent homelessness, and the increased likelihood that the foster youth have to place their children in foster care. This perpetuating cycle of adolescent childbearing, foster care placement and poverty is leading many foster care advocates and policymakers to explore new strategies to prevent pregnancy and to provide better support parenting among this vulnerable youth population.

An alternative perspective is that teen childbearing among foster youth does not always result in poor outcomes. Some foster youth have noted that having a child was their way of escaping their

risky lifestyle and making positive life changes *(Love et al., 2005; Pryce & Samuels, 2010)*. Having a child while in care may provide purpose and meaning to their life, which many foster youth crave. While few studies have examined the long-term outcomes for parenting foster youth, a study by Courtney et al. (2010) examined functioning among former foster youth transitioning to adulthood that participated in the Midwest Study. The study findings suggest four distinct subgroups of foster youth, one of which is categorized "struggling parents." This group (aged 23-24) makes up approximately 25% of transitioning foster youth. Most of these youth are likely to have at least one child living with them, and most likely to be married or cohabitating with a partner. They are unfortunately the least likely to have finished high school and to have attended college. Among struggling parents, only a small sub-group (25%) is currently employed, and approximately 70% receive need-based government benefits such as food stamps. However, struggling parents are among the least likely to have a criminal conviction *(Courtney et al., 2010)*. These outcomes demonstrate that this group is indeed struggling. They have significant needs for governmental support, but they mange to raise their children and avoid incarceration. While this is the only study that looks at long-term outcomes for young parenting former foster youth, there are potential lessons learned and policy implications for this group of parenting foster youth.

There is no shortage of promising interventions aimed at reducing sexual risk-taking and preventing potentially negative sexual outcomes among adolescents. Many program evaluations boast positive effects; however few offer credible evidence regarding the effectiveness of these programs due to significant design and methodological flaws *(Constantine, 2008)*. Two meta-analyses of intervention studies aimed at 1) reducing pregnancy-related outcomes among adolescents (Campbell Systematic Review) *(Scher et al., 2006)*, and 2) preventing unintended pregnancies among adolescents (Cochrane Collaboration) *(Oringanje et al., 2009)* demonstrate limited evidence of the impact of most interventions. However, the Campbell Review demonstrates promising results associated with intensive multi-component youth development programs serving higher risk adolescents *(Scher et al., 2006)*. Youth development programs strive to build strengths, skills, and possibilities among youth *(Benson et al., 2006)* while promoting the development of assets and protective factors that provide insulation from engagement in problem behaviors *(Catalano et al., 2010; Sesma Jr. & Roehlkepartain, 2003; Smith & Barker, 2009)*. Though youth development programs have demonstrated success in altering behaviors and impacting outcomes *(Philliber et al., 2002; Scher et al., 2006)*, they often require a significant human and financial investment that limits large-scale implementation.

Though these programs demonstrate success among general adolescent populations, and may not account for the unique needs of adolescents in foster care. Presently, few programs specially designed for the foster youth population have been developed and rigorously evaluated *(Constantine et al., 2009)*. One curriculum, *Power Through Choices*, was designed specifically for youth in foster care and takes into account their unique needs. This program incorporates youths' need for social support and trusted adults with whom they can discuss sensitive topics *(Becker & Barth, 2000)*. Despite showing promising results among the foster youth population, implications from this evaluation study are limited due to the small sample size and the non-experimental methodology. The dearth of available evidence of programs targeting foster youth highlights the need for comprehensive and longitudinal evaluations of such curricula to better assess programs that meet the unique needs of this population.

U.S. Child welfare system and provision of health services

Child welfare systems vary considerably by state, and procedures similarly differ from county to county. The child welfare system in the U.S. is not a single entity that operates in isolation. Services are often provided by multidisciplinary teams or through collaborations between departments of social services or child and family services and public and private service providers, including law enforcement officers, health care providers, mental health professionals, educators, legal and court system personnel, and substitute care providers.

When an abused or neglected child can no longer safely reside with his or her parents, the Juvenile Court will step in remove a minor from their parents. It is the goal of the court to determine what is in the best interest of the child to ensure safety and well-being. While in care, the court will make sure that the minors, families, and caregivers get the support services that they need. This includes guaranteeing that all involved professionals get the necessary information about the child and family to make well-informed and appropriate decisions. Such information can include medical histories and health information.

Historically, social workers have primarily been responsible for the case management of all services for foster care children, including the coordination of health care services. According to the federal Welfare and Institutions Code §16010, a case plan and court reports for every child in foster care must include a summary of the child's health and education information. In the mid 1990's, the American Academy of Pediatrics and the Child Welfare League of America established national guidelines for the provision of health care services for children in foster care, which called for collaborative initiatives between child welfare and health care systems to improve the health of foster children *(American Academy of Pediatrics Committee on Early Childhood Adoption and Dependent Care, 1994)*. Collaborative care has it benefits and challenges. While it is important for children and youth to receive comprehensive and multi-sectoral care, the reality and challenge of coordinating multiple individuals and organizations has drawbacks as well. Provision of care for this vulnerable population is critical since this group of children and youth lacks the necessary parental support to ensure that their health needs are appropriately met.

Necessary human and organizational capital

The challenge to protect our nation's most vulnerable children is clearly one that has no easy solution. The responsibility for protecting abused and neglected children is one that should be shared throughout society, but the greatest burden falls on our child welfare workforce. This frontline workforce responds to child abuse and neglect reports, they evaluate the safety of the children in question, and they make critical decisions regarding services provided to families and the removal of children from their homes. Once a child is removed from his or her home, child welfare agencies also secure safe placements in foster care or other out-of-home settings, they implement plans for preventing future abuse and neglect *(Ellett, 2009)*, and they coordinate care with a host of other providers.

The need for a highly competent and skilled professional child welfare workforce is imperative, yet the current context of the U.S. child welfare system makes it difficult to recruit and retain a highly qualified child welfare workforce. The nature of the work - high and complicated caseloads, for low pay, with insufficient training and support *(Ellett et al., 2007; Government Accountability Office, 2003)*, contributes to high employee turnover and low job retention *(Westbrook et al., 2009)*. In fact, the rate of annual turnover among child welfare employees has been estimated to be between 20% and 40% *(Government Accountability Office, 2003)*, demonstrating an unstable workforce.

This is a significant public, professional, and policy concern that must be addressed. As more counties across the U.S. are faced with increasing budget cuts and hiring freezes, further losses of child welfare workers will have devastating consequences for individual counties who will be forced to provide services with insufficient resources, staffing, and support. For a child welfare system already facing a myriad of challenges, these budget cuts will only serve to place a greater emphasis on the need for more effective and efficient health policies and programs for foster children and youth.

Current sexual and reproductive health policies for foster youth

The following section provides a brief background regarding what is known about sexual and reproductive health legislation and policies for foster youth. Some of the legislation does not directly relate to issues of sexual and reproductive health for foster youth, but stills has an indirect impact on this issue.

Early federal legislation

The federal government has authorized funding for child welfare services since 1935, through Title V of the Social Security Act. Since that time, the legislation has changed and evolved to provide greater levels of coverage to children in the child welfare system. In 1961, foster care funding was allocated for children in families that received support from AFDC (Aid for Families for Dependent Children), which was then part of the Title IV-B Child Welfare Services program. Then in 1980, the Foster Care and Adoption Assistance Amendments were passed (Title IV-E of the Social Security Act). This legislation stipulated reimbursement to states for providing care to children while in foster care, and adoption services for children for whom it was determined could not be returned to their biological families *(Child Welfare League of America, 2003)*. One of the requirements for children in foster care is that state child welfare agencies ensure that they receive an initial health care evaluation and receive an individualized health care plan. This provides an opportunity for youth to receive sexual and reproductive health screenings and services. Additionally, this legislation stipulates Medicaid eligibility to children in care through age 18. The recent Health Reform law will expand coverage to former foster youth to age 26 beginning in 2014 *(Boonstra, 2011)*.

Foster Care Independence Act

The John H. Chafee Foster Care Independence Act of 1999 was created to better support youth as they transition from foster care to self-sufficiency, by providing them with education, vocational and employment training and/or preparation for post-secondary education, daily living skills development, substance abuse prevention, pregnancy prevention and preventive health services, and connections to trusted and supportive adults. States are supposed to help youth develop a personalized transition plan that addresses these issues. The plan should also include a schedule for health screening, which can include sexual health screenings for youth. In developing the plan, case managers are encouraged to discuss issues of sexual health, services, and resources, to prepare youth to make healthy life decisions. *(Boonstra, 2011)*

One of the additional provisions of this legislation was greater flexibility afforded to states to design their own ILP programs to fit their state's context and child welfare needs. States provide services differentially across the state, using a variety of providers to deliver the ILP *(Child Welfare League of America, 1999)*. This piece of legislation is significant to the sexual and reproductive health policies of foster youth in that many counties primarily use their ILP programs to provide pregnancy related education. The challenge with providing sexual and reproductive health information to youth through ILP programs is that not all youth are eligible for this program or are able to attend ILP workshops. With this legislation, counties were afforded a high level of flexibility in how they administer their programs, which means that there is likely great variation in terms of the sexual and reproductive health education and support that youth receive. Additionally, counties across the country may provide greater or less access to ILP workshops for youth by virtue of how the program is administered and by whom.

Fostering Connections to Success and Increasing Adoptions Act

The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 became public law in October 2008. This substantive policy has been reported to be the most significant legislation to the foster care system in over 10 years, as it includes a host of new provisions and support systems for foster children and youth. Since its passage, this legislation has been selectively implemented across the US. In California, for example, Governor Schwarzenegger signed this legislation (AB 12) on September 30, 2010, which will extend care and services to foster youth until age 21 across the state. The goals of this extended program are to help foster youth continue to develop permanent connections with caring and committed adults, to develop independent living skills while exercising incremental personal responsibility, and to live in the least restrictive placement as possible. To be eligible for this voluntary program youth must reside in an eligible, supervised foster care placement, and they must meet one of the following criteria: 1) completing high school/GED equivalent; 2) enrolled in college/vocational program; 3) participating in a program designed to remove employment barriers; 4) employed at least 80 hours/month; or 5) unable to meet other criteria due to a medical condition. Implementation of this program in California began January 2012.

This legislation will ideally have a significant and positive impact on the overall physical and social welfare of foster youth. However, by extending the period of time that youth will receive support from child welfare staff and other associated supporters, this legislation also has an indirect impact on the sexual and reproductive health of foster youth. Foster youth who participate in this program have a greater opportunity to receive support regarding their sexual

health from child welfare providers, foster parents, and medical professionals. By extending Medicaid (Medi-Cal in California) eligibility, they can receive additional sexual health screenings and services. Alternatively, extension of services through this legislation further taxes and already stressed child welfare workforce.

A 50 state survey

A survey of all 50 U.S. states and the District of Columbia was conducted in 1996 through the Child Welfare League of America (CWLA) to ascertain: 1) state policies with provisions for sexuality education and family planning for foster youth placed in out-of-home care; 2) state policies with provisions for educational training for caseworkers and foster parents regarding topics related to sexuality; and 3) presence of pregnancy prevention programs. This survey found that only 10 states had written policies that addressed sexuality education and/or family planning services for youth. Seventeen states provided training for social workers, and only 11 states offered training for foster parents. The study also found that few states have education and prevention programs for foster youth in out-of-home care *(Mayden, 1996)*.

At this time, there is no current state-by-state inventory of reproductive health policies for children and youth in the child welfare system through any of the federal bodies that oversee child welfare. While the Mayden study provides a good overview of the national policy landscape for reproductive health policies for foster youth, the study is 15 years old. The current rates of teen pregnancy and childbearing among foster youth suggests the need to better understand the role that policy plays in facilitating or inhibiting healthy reproductive health among this population. Mayden suggests that policy shortcomings contributed not only to the overall confusion with respect to reproductive health policies for foster children and youth, but also to the inadequate response by child welfare agencies to address the need for adolescent pregnancy prevention *(Mayden, 1996)*. Other studies have noted similar gaps in reproductive health services and support for foster youth as a result of policy shortcomings *(Constantine et al., 2009; Love et al., 2005)*.

Sexual and reproductive health policies for foster youth in California

California Assembly Bill 1127 was added to Section 16521.5 of the Welfare and Institutions Code in 1996. This bill stipulates that foster care providers are required to ensure that adolescents in long-term foster care receive age-appropriate pregnancy prevention information. Foster care providers are also responsible for ensuring that foster youth receive referrals to health services when they reach age 18 or are emancipated, whichever occurs first. In both cases, if the provider objects, information should then be provided by county case managers. Unfortunately, Section 16521.5 also stipulates that these provisions would only apply to the extent that state and county resources were available. Additionally, the State Department of Social Services was to adopt regulations to implement this section. To date, however, no state funding has been allocated for these provisions *(Constantine et al., 2009)*. While this unfunded mandate was an admirable step toward improving sexual and reproductive health information and services for

foster youth, after more than 10 years, these provisions have not been actualized at the state and county level.

A study conducted in 2008 by the Public Health Institute (PHI) examined the sexual and reproductive health needs of both foster and transitioning youth in three California counties (Fresno, Orange, and San Francisco). This study included perspectives from Children and Family Services (CSF) staff and social workers, foster parents, ILP caseworkers, and former foster youth. Findings regarding the sexual and reproductive health needs and challenges of foster and transitioning youth were consistent with findings from other studies. This study found that California foster and transitioning youth had motivations for early childbearing, insufficient access to sex education, and poor utilization of contraceptives. Youth in this population also lack consistent one-on-one support from trusted and caring adults with whom they can discuss highly personal and emotional topics *(Constantine et al., 2009)*.

CFS social workers and ILP caseworkers cited lack of comfort in talking with foster parents/caregivers about these issues, and inadequate training in adolescent sexuality as barriers to providing youth with reproductive health information. The relevance of training for foster parents is still controversial. Some studies have shown that training yields only moderate gains in positive parenting, while other studies have shown significant effects *(Berrick, 2009)*. The influence of training in sexual and reproductive health has yet to be determined, but should not be ruled out as a strategy until further studies are conducted.

Additionally, diversity of religious and moral beliefs and values among CSF staff and foster parents/caregivers further complicates communication with youth. These challenges and barriers were heightened by a lack of clearly outlined roles and responsibilities within formal procedures. Additionally, unknown and non-existent policies regarding liability, parental rights, and youth confidentiality rights make discussing sexual and reproductive health with foster youth extremely complicated for CSF and ILP staff, and foster parents. The study concluded by making policy recommendations that included developing and implementing "specific policies, plans, and procedures to help prevent pregnancy and STIs, and to promote sexual health among foster youth" *(Constantine et al., 2009)*. It was suggested that these policies outline roles and responsibilities for all adults who care for youth, stipulate training for child welfare staff and foster parents/caregivers, and ensure that staff and caregivers routinely initiate discussions with you regarding sexual and reproductive health issues. Foster youth should have access to comprehensive sex education through ILP and non-ILP workshops; this should also include youth not yet eligible for ILP services due to age requirements. It was also recommended that pregnant and parenting youth received a full range of services on pregnancy options, prevention of subsequent pregnancies, and linkages to prenatal care. Additionally, information and resources for youth should be presented together on-site to facilitate youth access. Policies for foster parents and caregivers clearly stipulate that youth be allowed to attend sexual and reproductive health programs. Finally, the authors suggested that, "Section 16521.5 of the California Welfare and Institutions Code should be fully funded and implemented" *(Constantine et al., 2009)*.

The Constantine et al. (2009) study not only highlights the sexual and reproductive health needs of foster and transitioning youth in California, but it also proposes several policy recommendations that, if implemented, could provide youth with better access to education, services, and support. The present study provides an opportunity to expand on the current findings to further examine the state and county policies that address the sexual and reproductive health for foster youth in California, and to determine which counties have comprehensive

policies and how these policies affect the resources, services, and support that foster youth receive.

Why sexual and reproductive health policies for foster youth?

Children and youth placed in foster care are by definition individuals who have experienced neglect, maltreatment, displacement, and extreme uncertainty. They face a unique set of challenges not experienced by their peers, resulting in considerable physical, emotional, and psychosocial health disparities. Foster youth are at increased risk for negative sexual and reproductive health outcomes that can have a lasting impact on their health and wellbeing, and also the wellbeing of their children. Unfortunately, these children are often a forgotten group that receives insufficient attention and resource allocation unless an extreme and media worthy atrocity occurs that grabs our attention and shakes us from our complacency.

Despite the compelling challenges faced by foster children and youth, how can we encourage society at large and policymakers to care about foster children and youth, and why should they pay particular attention to their sexual and reproductive health? Given the strained child welfare system and the acute budget crisis sweeping the nation, we need a compelling justification to satisfy policymakers and motivate them to allocate resources to support this vulnerable and underserved population.

The costs to California's taxpayers associated with teen childbearing were approximately $1 billion, with an annual cost to society at large of $4 billion in 2009 *(Constantine et al., 2012)*. While there are no California data indicating how many adolescent foster youth become pregnant or have children while in care, there is evidence that foster youth are more likely to become pregnant and experience early childbearing than their adolescent counterparts not in care. The potential cost savings to taxpayers and society as a whole is a persuasive argument for promoting healthy sexual and reproductive health among these youth.

What is the role of formal child welfare policies in addressing the sexual and reproductive health of foster youth? Some studies have demonstrated the need for written procedures that address pregnancy prevention for foster youth for caseworkers, foster parents, and foster youth. They recommend that policies include well-defined roles and responsibilities for caseworkers and caregivers *(Constantine et al., 2009; Love et al., 2005)*, and that the policies stipulate training support for caseworkers, child welfare staff, and foster parents on multiple topics related to youth sexual and reproductive health *(Haight et al., 2009)*. It is also recommended that policies regarding the recruitment and training of foster parents and caregivers should address youth rights to access information and services related to their sex education and reproductive health *(Constantine et al., 2009; Love et al., 2005)*.

Given the recommendations and current child welfare resource constraints, it is necessary to examine the content, context, and influence of existing sexual and reproductive health policies. This information will provide a basis for understanding how departments of children and family services can improve youth access to sexual and reproductive health information and services through policy formation and implementation.

CHAPTER 3: Theoretical Framework

Foundational theories of the policy process

The question of how some ideas and policy proposals become public policies while others do not is widely examined and debated in the literature. The classic model of the policy process operationalized by Harold D. Lasswell depicts a policy process consisting of functional stages or phases that policies or programs undergo during the policy life. This rational and linear process of policy decision making begins with problem identification, and is followed by debate and legislation. In this model the implementation that follows is largely legislative interpretation and compliance by local actors responding to well-defined statues. While the concept of policy stages provides a way of conceptualizing and operationalizing the policy process *(Weissert & Weissert, 2006)*, it has been argued that this rational model does not account for the often disjointed, episodic and unpredictable nature of policymaking *(deLeon, 1999; Mucciaroni, 1992)*.

The process of agenda setting in policymaking

Kingdon (1984) poses an alternative to the classic model of policy change by adapting the Garbage Can model of organizational choice developed by Cohen, March and Olsen *(Cohen et al., 1972)* to explain the policy and agenda setting process within a political context *(Quirk, 1986)*. Kingdon's model denotes a process that is unpredictable and dynamic, with elements of both order and disorder *(Kingdon, 1984)*. The model depicts separate policy elements, or streams, intersecting as if thrown together in a garbage can at one time. The three streams (problems, policies, and politics) develop and operate fairly independently, and eventually come together at a critical time. When this occurs, a problem is recognized, a policy solution is deemed available, and the political climate is right. The convergence of these streams at an opportune time allows for an issue to move from discourse to a public agenda for policymaking to occur *(Kingdon, 1984; Weissert & Weissert, 2006)*.

Kingdon's Garbage Can theory does not depict a rational or linear policy process that logically progresses from problems and solutions to policies. There are instances where a newly attractive and feasible solution will precede the articulation of a particular problem. Additionally, elevating a problem in the public sphere does not necessarily imply the use of any particular solution; rather any number of possible policy solutions may be identified to address a particular issue. Finally, the politics of the policy process reflect current political conditions that can favor or oppose a particular policy, such as changes in national mood, election results and government administrations. This model emphasizes the importance of the political context in the policy process. Regardless of the presence of a compelling problem and attainable solution, without amenable political conditions policy change will likely fail *(Kingdon, 1984; Mucciaroni, 1992; Weissert & Weissert, 2006)*.

The model suggests the importance of timing, as there is a critical window of opportunity for the confluence of these three policy streams to come together. The policy window is often short-lived, requiring that specific conditions be met for agenda setting to occur. The independent nature of each policy stream complicates the policy process, as any number of variables within

an individual stream can change unpredictably and throw the entire process off course *(Cohen et al., 1972; Kingdon, 1984; Mucciaroni, 1992; Weissert & Weissert, 2006)*. If the problem is not considered salient enough, and/or an appropriate and feasible solution is not identified, and/or the right political conditions are not present, then the issue will not sufficiently rise to a policy agenda. For example, if the "balance of political forces changes (and sometimes even if it doesn't), so will the agenda" *(Quirk, 1986)*. These features of Kingdon's model further highlight the unpredictable and unsystematic nature of the policy process, and the importance of seizing opportunities for policy change during critical policy windows.

Given the unpredictable nature of the policy process described by Kingdon, it is important to explore which problems are recognized and considered worthy of attention from public officials. Kingdon describes this as a very political process *(Kingdon, 1984)*, where only a handful of problems ever get necessary consideration from public officials to rise to the level of political agendas *(Weissert & Weissert, 2006)*. Governments must see the issue as a social problem, they must believe they have the capacity to respond, and they must be compelled to respond. When problems are believed to stem from human or government sources and they are perceived to be amenable to policy solutions, then governments are more likely to take action. Policymakers are inclined to make policy decisions based on their desire to balance and prioritize personal views, perceptions of voter preferences, relationships with party leaders, and electoral popularity *(Weissert & Weissert, 2006)*. The problem definition process is not easy and straight forward, and problems do not simply exist in the public sphere waiting to be solved *(Baumgartner & Jones, 2009)*. Instead they need to be well formulated and defined in context of current political conditions to garner necessary support for a desired position *(Mucciaroni, 1992)*.

Kingdon's analysis of agenda setting provides a broad framework for examining the complex and unpredictable process of defining problems and identifying policy solutions within the political sphere. Stone (2002) expands upon this model by describing the role of causal stories in defining problems for public discourse. She describes a process of "active manipulation of images of conditions by competing political actors" *(Stone, 1989, p. 299)* to set the parameters necessary to discuss and bring legitimacy to an issue. Stone explains the role of political actors in creating causal stories that articulate the harms and difficulties associated with a particular issue. They attribute causes to the actions of individuals and/or organizations in an effort to invoke the need for governments to address the problem and use their "power to stop the harm" *(Stone, 1989, p. 289; 2002)*. Causal stories have multiple uses in the political sphere that include: 1) challenging or protecting existing rules, institutions and interests; 2) assigning responsibility for fixing a problem to particular policy actors; 3) legitimizing and empowering actors in their role as "fixers" of the identified problem; and 4) creating new political alliances among individuals perceived to be similarly harmed by the problem *(Stone, 2002)*.

It should be noted that the strategic use of causal stories is not the result of one individual policymaker. Multiple experts work together to identify and accept one causal story that accordingly shapes the trajectory of the policy process and the resulting governmental response *(Baumgartner & Jones, 2009)*. The desired result for these policy actors is an intentionally applied and successful causal story that establishes a compelling and feasible problem that reaches the appropriate public agenda *(Stone, 2002)*. Stone's application of causal stories provides a salient elaboration of Kingdon's agenda setting theory that can be applied to examinations of problem recognition and definition during the policy process.

The role of policy actors in agenda setting

Kingdon (1984) suggests that no single policy actor, or group of participants has the ability to dominate the agenda setting process and single handedly direct attention and action to a new issue or problem; a notion similarly echoed by Stone (2002). Within the context of the complex and unpredictable policy process, deliberate efforts must be taken to seize the critical opportunity for agenda setting when the necessary policy streams are aligned and amenable to policy change. Ensuring this occurs before conditions change, requires involvement from policy entrepreneurs—"highly knowledgeable, committed individuals in or out of government—who are willing to invest their resources to join the streams together" *(Mucciaroni, 1992, p. 461)*. Policy entrepreneurs include but are not limited to: appointed cabinet staff, senators or representatives, lobbyists, academics, lawyers, journalists, and bureaucrats *(Weissert & Weissert, 2006)*.

Despite the independent and unpredictable nature of the policy streams, there is the possibility that chance, human creativity and choice can influence potential outcomes *(Mucciaroni, 1992)*. As key actors in the policy process, successful policy entrepreneurs are capable of developing and articulating problems and policy solutions that are deemed plausible and compelling given current political conditions. They also use their skill and persistence to formulate the link between streams, and negotiate with other stakeholders to for these critical couplings. If a given issue has several different implications, policy entrepreneurs shift the public's view from one set of implications to another to ensure that his/her favored solution is adopted *(Baumgartner & Jones, 2009)*. According to Kingdon, these are very deliberate actions that require policy entrepreneurs to be alert and ready to seize opportunities to push their proposals higher up on the public agenda when the policy window opens *(Kingdon, 1984)*.

Though his work on agenda setting, Kingdon demonstrates an interesting division of labor among the involved policy actors, with identifiable clusters of activities and actors. He argues that elected officials (i.e. presidents, cabinet secretaries, prominent members of congress, and party leaders) are among the most important category of actors in explaining why some issues receive necessary attention. Conversely, he believes that lower level civil servants and specialists (i.e. interest groups, academics, researchers, and consultants) are less influential in agenda setting, and more influential in designing policy alternatives and solutions *(Kingdon, 1984; Quirk, 1986)*. While Kingdon's theory of agenda setting provides a foundation for understanding the role and contribution of multiple actors in the policy formation process, other theorists also examine the influential role of policy actors in this process.

Baumgartner and Jones (1991 and 2009) offer significant contributions to the agenda setting process. In *Agendas and Instability in American Politics*, they propose a model for policymaking that moves beyond the concept of incrementalism to suggest a theory of punctuated equilibrium that accounts for long periods of policy stability punctuated by periodic bursts of policy change. They describe the role of policy subsystems (i.e. interactive networks of legislatures, interests groups, agencies, and beneficiaries) in supporting stability or change. Subsystems fundamentally promote stability when they are insulated from new policy ideas and policy competitors, and they provide stability for members of the subsystem. However, subsystems can completely collapse and result in a change to the status quo when forces external to the subsystem mobilize and challenge the existing subsystem.

Baumgartner and Jones describe how the infusion of new ideas and voices from previously uninvolved or excluded institutional venues can persuasively challenge or reframe traditional or formerly dominant thinking around a particular policy issue. The articulation of these new ideas from new venues can also mobilize the involvement and action of formerly apathetic actors. If successful, the participation of these new actors can result in dramatic policy change. New actors and institutional venues offer a new way of looking at a problem, pose new problems, or redefine the dimension of conflict associated with a problem *(Baumgartner & Jones, 1991*, *2009; Cohen, 1994)*. Policy entrepreneurs exploit opportunities to define issues by strategically recruiting participation from previously uninvolved and sympathetic venues, or by excluding participation from others. Additionally, Baumgartner and Jones also suggest that there are "no immutable rules that determine which institutions in society will be granted jurisdiction over particular issues" *(Baumgartner & Jones, 1991, p. 1047)*. Participating institutions and groups can share jurisdiction over a policy venue, or the issue will be in the domain of a select set of institutions. With the variations in venues comes differences in participants and institutional decision making routines and biases *(Baumgartner & Jones, 1991*, *2009)*.

In this model, Baumgartner and Jones describe the mobilization of new voices and interests as occurring during waves of enthusiasm for a policy (Downsian mobilization), or as a result of opposition and criticism of the policy status quo (Schattschneiderian mobilization). Both types of mobilization have different outcomes. The positive policy images characteristic of Downsian mobilization, result in the possible creation of new institutions that support the status quo and continued subsystem hegemony. Alternatively, Schattschneiderian mobilization, involves the use of negative policy images that are more likely to result in the destruction of old subsystems and the creation of new subsystems, ultimately causing bursts of change. The domination of either of these types of mobilization describes the stability of the subsystem, and the possibility of change occurring. This model not only counters the traditional view of policymaking as a process of incremental change, but it also ties together the role of new institutional venues in establishing problem definition, promoting or challenging the policy status quo, and contributing to policy stability or change. The description of the role of new actors and venues most appreciably contributes to the model of agenda setting outlined in Kingdon's adapted Garbage Can model.

In summation, regardless of how well problems are defined, some issues fail to result in change, while other seemingly poorly defined issues result in policy change. Kingdon's model of agenda setting provides a basis for examining how critical issues gain agenda access and how new ideas are infused into the policy process through a highly unpredictable, non-rational and political policy process. This model, along with Stone's elaboration of problem definition and Baumgartner and Jones's (1991 and 2009) description of the role of new institutional venues in agenda setting, provide a comprehensive framework for examining key features of the policy process. These theories support the examination of a highly complex, unpredictable and disorderly agenda setting process *(Baumgartner & Jones, 1991*, *2009; deLeon, 1999; Kingdon, 1984; Mucciaroni, 1992)*, which departs from the more rational and linear classic model of policy change originally outlined by Lasswell *(Weissert & Weissert, 2006)*and recognizes the "important role of chance, innovation and human agency in policymaking" *(Mucciaroni, 1992, p. 482)*.

Foundational theories of policy implementation

Since the 1970's, considerable research on policy implementation demonstrates significant variations in analytical methods, and evolutions in the field as a whole *(O'Toole, 2000)*. Implementation theory conceptualizes and analytically examines how and why policies are put into effect and who is responsible for achieving outcomes and policy success. Schofield (2001) argues that within this body of research there are three generations of analytical models that study policy implementation. The first-generation models identify factors that describe the policy implementation process, and assume that the process is rational and linear with largely distinct and separate formation and implementation activities. These studies also identify great complexity within public administration and policy spheres, and view implementation as a function of the success or failure of bureaucrats to comply with primary legislative directives. The second-generation models are more analytical in their emphasis on developing typologies for predicting policy outcomes and the key variables (policy, organization and people) that have positive and negative implementation implications. According to Schofield (2001), these models do not always hold during periods of uncertainty and rapid policy innovation. Lastly, the third-generation models account for the dynamism and unpredictability of policy implementation. These studies employ longitudinal methodologies and examine the interaction between different legislative levels to identify interactions in terms of facilitating factors and constraints to implementation. This model focuses analysis around legislative and organizational bodies at the federal, state, and local implementation levels, and draws in aspects of inter-agency coordination and cooperation *(Schofield, 2001)*. Schofield's (2001) synthesis provides a historical overview of the development and transformation of the implementation literature, highlighting fundamental distinctions and providing a basis for further examining the theories.

Top-down and bottom-up approaches

Multiple theorists in the field have sought to examine and explain implementation across programs and governmental units *(Schofield, 2001)*. There are two dominant models for describing and studying policy implementation, which are broadly differentiated by 'top-down' versus 'bottom-up' perspectives. The top-down approach proposes that policy implementation starts with policy designers (central actors) who make policy decisions, often in the form of well defined statutes or mandates, that lead to legally-mandated objectives that are implemented over time by local level actors *(Sabatier, 1986)* in a linear and rational fashion *(Schofield, 2001)*. Central actors (often governmental officials) responsible for making authoritative decisions are perceived to be essential to producing desired policy effects *(Sabatier, 1986)*. As such, they establish the control measures and boundaries for implementation by local level implementers *(Schofield, 2001)*. Critical features of the top-down approach include: 1) the extent to which the actions of implementing officials and target groups are consistent with a policy decision; 2) the extent to which objectives are reached over time; and 3) the key elements affecting policy outputs and impacts. Additionally, Mazmanian and Sabatier (1981) suggest six variables that they believe are generally necessary conditions for effective implementation. They include: 1) clear and consistent objectives; 2) adequate causal theory; 3) implementation process that is legally structured to enhance compliance by implementing officials and target groups; 4) committed and skillful implementing officials; 5) support of interest groups and (political)

sovereigns; and 6) changes in socio-economic conditions that substantially undermine political support or causal theory *(*Mazmanian and Sabatier (1981); cited in *Sabatier, 1986)*.

Criticisms of the top-down approach include its failure to "recognize the role of political rhetoric in policy formation" and the relevance of actions occurring during the pre-legislative phase of policymaking *(Schofield, 2001, p. 251)*. This underscores the political nature of problem definition and importance of overall political conditions in the policy process *(Baumgartner & Jones, 2009; Kingdon, 1984; Mucciaroni, 1992)*. This model also focuses on the role of central level actors responsible for statute formation, and neglects the perspectives and contributions of local level bureaucrats and service deliverers with first-hand expertise and knowledge regarding implementation *(Sabatier, 1986)*. The top-down model views local actors as "impediments to successful implementation, agents whose shirking behaviors need to be controlled" *(Matland, 1995, p. 148)*, which does not account for the behavioral complexity associated with these actors. Finally, the top-down model does not account for the messiness of policymaking; a key aspect of the policy process depicted in Kingdon's model that illustrates the complexity and unpredictability of entire policy process *(Kingdon, 1984; Schofield, 2001)*.

In the late 1970's and early 1980's the "bottom-up" approach emerged as an alternative model, addressing some of the criticisms and shortcomings of the top-down approach *(Sabatier, 1986)*, and accounts for the variation that takes place at the local level following policy implementation *(Matland, 1995)*. Hjern (1982) pioneered the bottom-up approach to develop an analytic strategy for studying the role of micro-level actors. His approach begins with identifying the network of actors involved in service delivery to assess their goals, activities, problems, and contacts. The contacts are then used to expand the network to include local, regional, and national actors involved in the execution of the program. He articulates an implementation process moves from local actors and bureaucrats at the bottom level to central level policymakers at the top. He maintains that program success is far more dependent on the skills of individuals within local implementation structures as opposed to those in central government spheres *(Hjern, 1982)*.

The bottom-up approach places a larger emphasis on the target groups and individuals responsible for delivering services, viewing these local actors and bureaucrats as the agents ultimately responsible for determining policy. These individuals are referred to as "street-level bureaucrats" that largely work in the public service sector (e.g. teachers, social workers, and police officers). Lipsky (1980) argues that street-level bureaucrats, through the routines that they establish and the devices that they develop to cope with work uncertainties and varying contextual factors, effectively adapt to their policy environments and embody the policies they are responsible for carrying out or risk program failure *(Matland, 1995)*. The decisions that these individuals make often become agency policy *(Lipsky, 1980)*, regardless of what the government policies stipulate. In the bottom-up model local actors respond to macro-level plans developed by central actors, but ultimately operate at the micro-implementation level using considerable discretion to develop their own programs and implementation strategies *(Sabatier, 1986)*. This leaves policy designers unable to ultimately control the policy implementation process *(Matland, 1995)*.

A key facet of the bottom-up approach is the decreased focus on the attainment of formal policy goals and objectives as outlined in the top-down model, which allows for the examination of various unintended consequences of governmental and private programs. Those who ascribe to the bottom-up approach, place a greater emphasis on describing the factors that have inhibited reaching stated goals rather than focusing on goal attainment. Furthermore, due to the inclusion

of a wide range of network actors, bottom-up research is better able to deal with strategic interactions and motives of various actors, allowing for flexibility and adaptation to meet local contextual conditions *(Matland, 1995; Sabatier, 1986)*. While the role of local actors is key to bottom-up approach, the overemphasis on the local peripheral actors potentially neglects the central decision making actors and policy. This underestimates the influence that central level actors have on the larger institutional structures in which the local actors operate. Furthermore, the reliance on the perceptions and activities of participants overlooks factors that indirectly affect their behavior (e.g. factors that participants are not be aware of) *(Sabatier, 1986)*. Lastly, the complexity of the actions and interactions of multiple actors, organizations and networks limits this mode's explanatory capacity *(Schofield, 2001)*.

The complexity associated with policy implementation

An in-depth case study and analysis of policy implementation conducted by Pressman and Wildavsky (1984) demonstrates the complexity associated with the 'nitty-gritty' facets of implementation *(O'Toole, 2000)*. The authors suggest that policy implementation is not simply the act of developing policies for straightforward and technical compliance. Instead, implementation involves a host of actors with different problem definitions, goals and objectives, and resources. This policy analysis demonstrates the significance of joint action and relevance of multiple clearance or veto points; where each decision point requires action by involved actors to move forward. The authors conclude that unless the probability of agreement at each clearance point is exceedingly high by every participant, there will be little chance of implementation success. Pressman and Wildavsky (1984) further emphasize the political nature of policies, governing bodies and local stakeholders, and highlight the importance of considering multiple contextual factors *(Pressman & Wildavsky, 1984)* when examining policy implementation. Their work also lends credence to the bottom-up approach, which bases much of policy implementation on local actors' ability to adapt to contextual factors and use discretion in shaping implementation programs and strategies.

The top-down and bottom-up approaches both account for relevant elements of the implementation process. Some theorists suggest the application of one model over the other when appropriate and under certain conditions, while others advocate the use of a combined model during different phases of the implementation process *(Sabatier (1991 and 1993); Sabatier and Pelkey (1987); cited in: Matland, 1995; Schofield, 2001)*. While there are differences in the analytical methods and the applicability of the different approaches for examining policy implementation, the theories significantly contribute to the conceptualization of how and why policies are put into effect and who is responsible for achieving outcomes and policy success.

Research questions

> **Central Research Question:** What are the content and context of sexual and reproductive health practices for foster youth in California?
>
> **<u>Research Question I:</u>** What are the policy formation process and history, implementation status and policy stakeholder experiences for a selected county with a known sexual and reproductive health policy?
>
> **<u>Research Question II(a)</u>**: What are the county practices in California related to foster youth sexual and reproductive health needs, rights, services, and education?
>
> **<u>Research Question II(b)</u>**: What are the key issues relevant to county-level sexual and reproductive health policy practices among a sample of California counties? How are these issues consistent or inconsistent with those identified in the case study of Santa Clara County?

Theoretical framework for examining policies for foster youth

Figures 1 and 2 below draw together relevant policy process and implementation theories that are applicable to the study of sexual and reproductive health procedures for foster youth in California. These theories provide the framework for examining the dissertation *Research Questions I and II(b)*, that focus on the policy formation and implementation processes. *Research Question II(a)* is a description of current procedures, and does not have a direct application to the policy theories; as such links between this question and policy theories are not applicable.

<u>Research Question I:</u> *How does one county's policy formation process and history, implementation status and stakeholder experiences map to theoretical frameworks for policymaking?*

Research Question I aims to map theoretical frameworks for policymaking to the policy formation process and history, implementation status and stakeholder experiences of a California county with a formal sexual and reproductive health policy for foster youth. The overall policy process is examined using Kingdon's adapted Garbage Can model of agenda setting and policymaking. Using this model the three policy streams are explored independently to gain an in-depth understanding of how problems were recognized, the identification of available solutions and the political context that contributed to agenda setting and policy formation in the identified county *(Kingdon, 1984)*.

> ***Research Question I***
> **Study domains**
>
> *Policy formation*
> - Problems
> - Solutions
> - Political context
> - Problem definition
> - Policy entrepreneurs
> - Venues
> - Timing
>
> *Policy implementation*
> - Central level actors
> - Local level actors
> - Policy mandates
> - Contextual factors

As noted by Kingdon (1984) and Baumgartner and Jones (1991 and 2009), policy actors and policy entrepreneurs have an important role in the policy process, both with respect to contributing to problem definition and strategic involvement of actors from influential policy venues. Within the context of this research question it is necessary to examine the actors that participated in the policy process, their associated roles, and the extent to which some actors are considered policy entrepreneurs. Specific factors for examination include how policy actors from new institutional venues contributed to framing and articulating problems and solutions *(Baumgartner & Jones, 1991, 2009)*. Examination of these policy factors (*Figure 1*) illustrates the extent to which each of these factors contributes to policy formation in one California county with a known sexual and reproductive health policy.

Implementation is a dynamic interaction between policy and setting that involves multiple stages and decision makers, engaged in joint action and coordination, who have conflicting organizational goals and priorities *(Pressman & Wildavsky, 1984)*. Policy implementation theories provide a framework for exploring the implementation status and policy stakeholder experiences of a county with a known sexual and reproductive health policy. Factors associated with both the top-down and bottom-up approaches (*Figure 2*) *(Hjern, 1982; Sabatier, 1986)* are examined to understand the possible application of a singular or combined approach to policy formation and implementation. Specific factors for exploration include: the role and experiences of central and local level actors, the application or interpretation of policy mandates and the contribution of pre-existing contextual factors in shaping implementation (i.e. the presence of political, organizational and resource constraints, and multiple clearance points). Together these implementation theories provide a framework for examining the implementation status and policy stakeholder experiences of the county with a known sexual and reproductive health policy.

Research Question II(a)*: What are the county practices in California related to foster youth sexual and reproductive health needs, rights, services, and education?*

As noted above, *Research Question II(a)* is a description of current procedures, and does not have a direct application to the discussed policy formation and implementation theories. Consequently, links between this question and policy theories are not applicable for discussion in this section.

Research Question II(b)*: What are the key issues relevant to county-level sexual and reproductive health policy practices among a sample of California counties? How are these issues consistent or inconsistent with those identified in the case study of Santa Clara County?*

Research Question II(b) examines the key issues relevant to county-level policy practices, among counties both with and without policies. Kingdon's adapted Garbage Can model provides the overarching theoretical framework for examining the three policy streams (problems, solutions, and political context) *(Kingdon, 1984)*. Since it is anticipated that the majority of counties do not have

Research Question II(b)
Study domains

Policy formation
- Problems
- Solutions
- Political context
- Problem definition
- Policy entrepreneurs
- Venues
- Timing

formal sexual and reproductive health procedures for foster youth, this theory will have an altered application from what was applied in *Research Question I*. For example, instead of examining how problems were recognized, the focus is the presence of problem recognition and the extent of that recognition. It is also important to explore whether stakeholders identify or propose innovative solutions to addressing the recognized problems. If so, are these solutions compatible with policy change and the current political conditions? As with *Research Question I*, it is also important to explore the role of policy entrepreneurs, except for this question the focus shifts to potential policy entrepreneurs who could responsible for influencing policy streams given other necessary policy conditions. Analysis of these factors provides a basis for examining the relevance and acceptance of sexual and reproductive health policies for foster youth among counties across the state.

Figure 1. Theoretical framework for examining the policy process

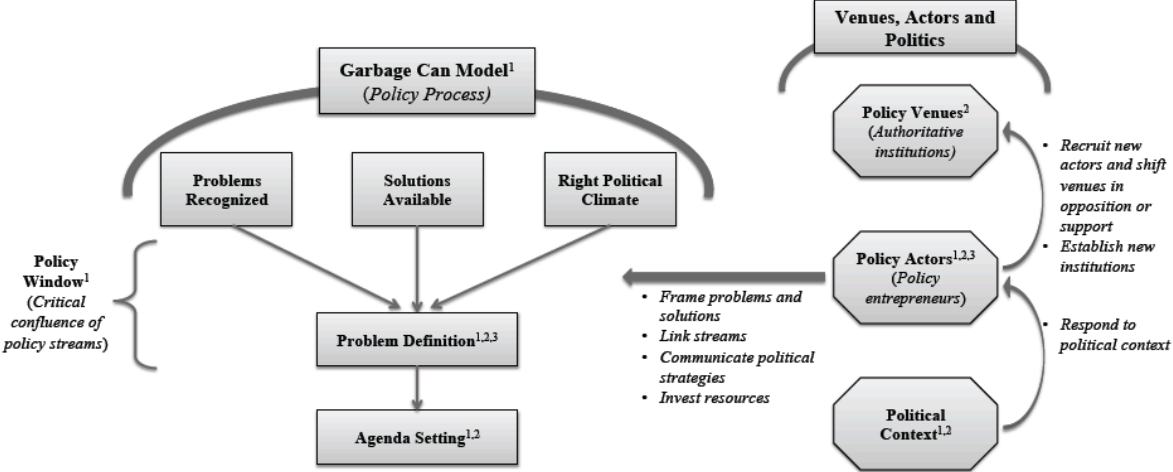
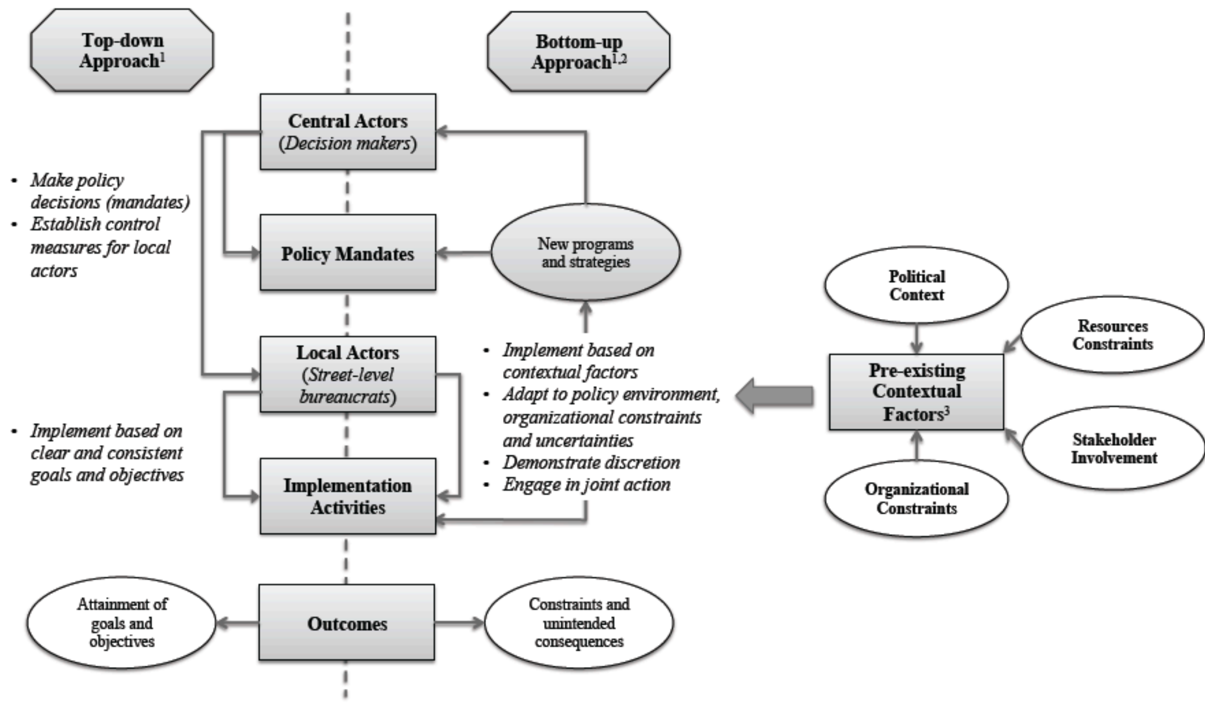


Figure 2. Theoretical framework for examining policy implementation



CHAPTER 4: Methods

Research questions

Central Research Question: What are the content and context of sexual and reproductive health practices for foster youth in California?

Research Question I: How does one county's policy formation process and history, implementation status and stakeholder experiences map to theoretical frameworks for policymaking?

Research Question II(a): What are the county practices in California related to foster youth sexual and reproductive health needs, rights, services, and education?

Research Question II(b): What are the key issues relevant to county-level sexual and reproductive health policy practices among a sample of California counties? How are these issues consistent or inconsistent with those identified in the case study of Santa Clara County?

Methods Section I: Santa Clara County case study of policy formation & implementation

Research question I was answered through an in-depth case study of one county with a formal sexual and reproductive health policy for foster youth. Case study methodology was used to gain a greater understanding of the policy formation process and history, implementation status, policy stakeholder experiences, issues and challenges, and strengths and weaknesses of this county. The case study involved the following: 1) conducting interviews with county experts, and 2) reviewing public documents deemed relevant by the study participants. Since this research question primarily relied on the perceptions of county experts who were knowledgeable about health and social policies related to foster youth qualitative data collection was warranted. Key informant interviews were conducted with multiple policy stakeholders representing diverse perspectives and specialties, depicting the county's policy formation and implementation story. The Institutional Review Board of the University of California Berkeley approved the following study protocol and recruitment methods.

Case selection

Santa Clara County (SCC) was selected as the most appropriate and feasible target county for the case study. SCC was one of two counties with a known sexual health policy for foster youth. Prior to this study, a pilot interview was conducted with a SCC social worker that managed the

formation and implementation of the county's sexual and reproductive health policy. This individual expressed interest in participating in the larger case study. While Los Angeles County also had a documented and publically available policy, due to lack of contacts and proximity to potential stakeholders it was determined to be less feasible for study examination.

Study participant sampling and recruitment

To maximize the range of key perspectives snowball sampling was used to progressively identify study participants most involved and relevant to the policy process in SCC. The first interviewee was purposively identified as an individual from the SCC Department of Family and Children's Services (DFCS) knowledgeable about sexual reproductive health for foster youth—someone in a supervisory role responsible for overseeing or coordinating relevant policies and programs. Subsequent study participants were identified following the initial interview, and recruited for participation. Participants were selected to maximize diverse perspectives and specialties, and sampling was continued until redundant information was achieved. Descriptions of the participating county agencies and community organization are found in *Appendix I*.

Table 1 below lists the represented agencies and organizations, and the title of each study participant. Study participants included DFCS staff, juvenile court judges, a representative from SCC Legal Council, a representative from the probation department, a medical professional, and representatives from Planned Parenthood Mar Monte. All of the participating study participants were identified as influential stakeholders in the policy process.

Table 1. Case study participant agencies/organizations and titles

Agency/Organization (*Policy venues*)	**Study participant titles (*Policy actors*)**
Santa Clara County Department of Family and Children's Services	1. Foster care supervisor 2. Program manager
Superior Court of California: Santa Clara County	3. Juvenile justice court judge 4. Juvenile dependency court judge
Santa Clara County: Office of the County Council	5. Attorney
Santa Clara County Probation Department	6. Probation supervisor
Santa Clara County Juvenile Hall Clinic	7. Physician
Community organization: Planned Parenthood Mar Monte	8. Program director 9. Program coordinator

Figure 3 below outlines the results of the snowball sampling process. The figure indicates the initial study participant along with the subsequent study participants, and depicts the corresponding snowball sampling linkages. Two individuals from other organizations identified during the snowball sampling process did not reply to request to participate (Public Health Department and Independent Living Program). Additionally, the initial DFCS representative

suggested that a former foster youth involved in the policy formation process also participate in the study. However current contact information for a participating youth was not provided by DFCS. A total of nine individuals participated in the expert interviews, representing six agencies and organizations. *Figure 4* below summaries the relationship among the participating agencies and organizations (hatched boxes indicate participants).

Figure 3. Case study snowball sampling process

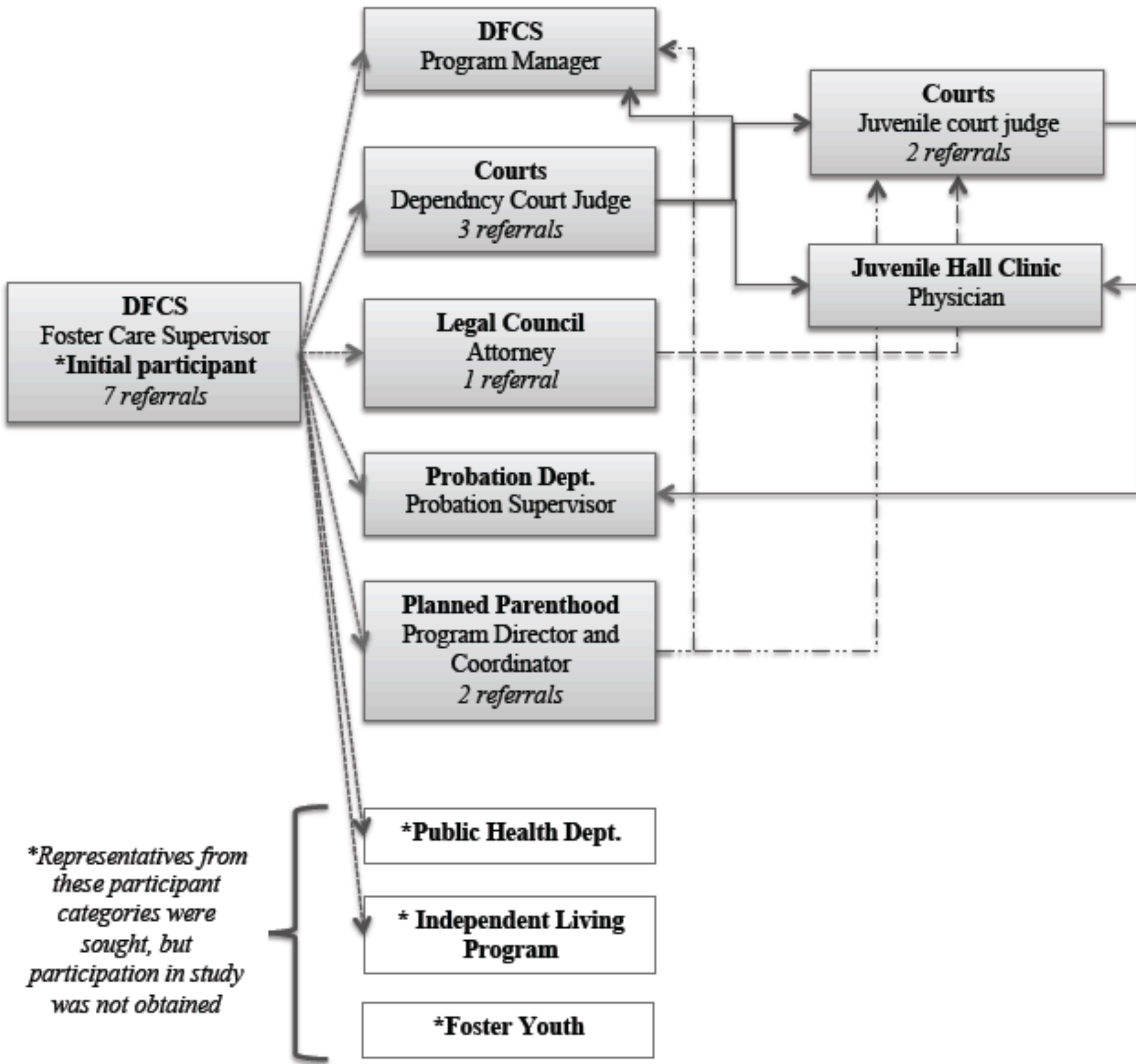
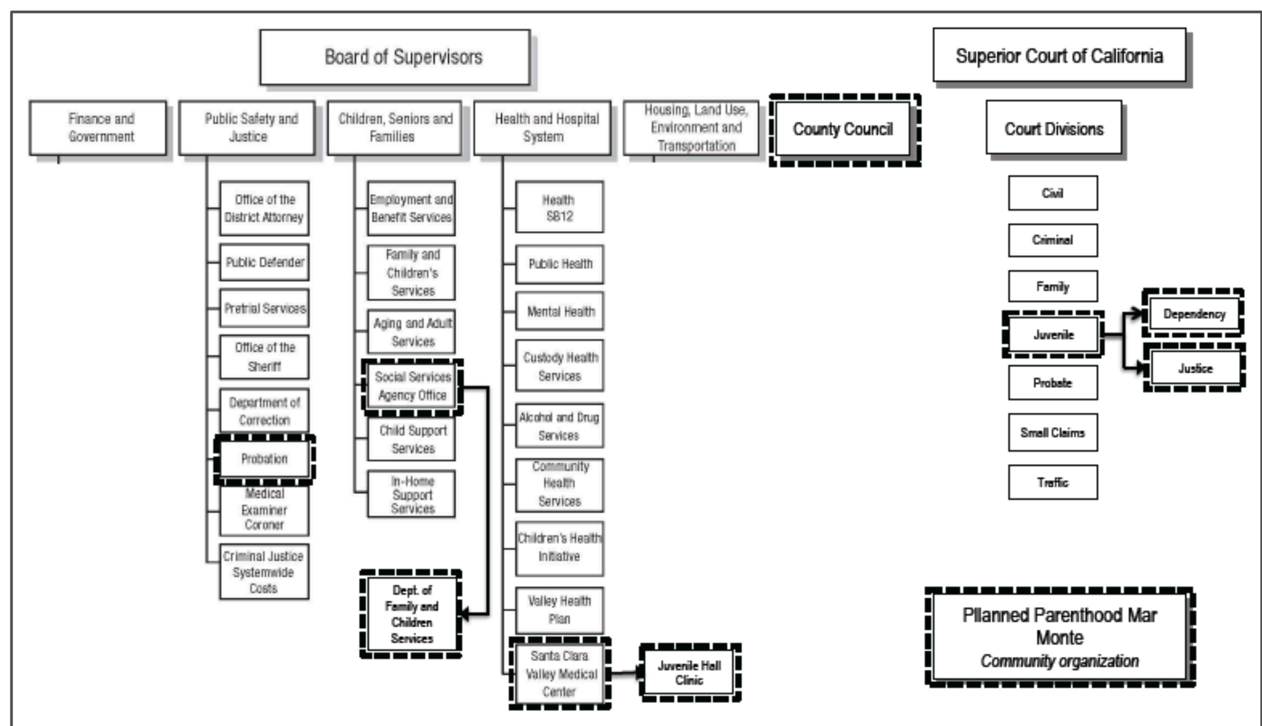


Figure 4. Organizational chart of participating agencies and organizations



Sources: 1) County of Santa Clara government website, FY2013 Recommended Budget "Introduction" at http://www.sccgov.org/sites/scc/countygovernment/Documents/FY13RecBudget/Introduction.pdf; 2) Superior Court of California: Santa Clara County website at http://www.scscourt.org

Document review

Participants in the expert interviews were asked to share any supplemental documents relevant to the study, and added necessary context to the policy process (*Table 2*). All of the documents were qualitatively analyzed along with the interview transcripts. A total of two documents were obtained. These documents included the following: 1) History of the Reproductive Health and Safety Task Force (March 29 and 20, 2010), and 2) Report of the Reproductive Health and Safety Task Force (March 1, 2010).

Table 2. Santa Clara County supplemental policy documents

Title	Date	Description
History of the Reproductive Health and Safety Task Force	March 29 & 30, 2010	History of the Reproductive health and safety task force for presentation at a 2010 Bench Tool Planning Meeting hosted by the National Council of Juvenile and Family Court Judges and the National Campaign to Prevent Teen and Unplanned Pregnancy. Presented by a SCC juvenile court judge.
Report of the Reproductive Health and Safety Task Force	March 1, 2010	Final report of the Task Force prepared for the SCC Board of Supervisors, SCC Blue Ribbon Commission on Foster Children and Youth and Juvenile Justice Commission. Details task force accomplishments, sexual and reproductive health services for court-involved youth in SCC, and Task Force recommendations.

Expert interview protocol

Expert interviews were conducted in-person and via telephone by the study investigator. Interviews were designed to last approximately 60 minutes. Open-ended questions and prompts increased the scope and depth of responses to allow participants the opportunity to express, in an unrestricted manner, experiences and insights. All interviews were audiotaped and transcribed verbatim and reviewed for accuracy by the study investigator.

Qualitative theme analysis

Qualitative analysis was conducted using *NVivo©* software to input, organize and code data. The software additionally identified potential relationships and general themes. Manual transcript-based theme analysis was subsequently conducted, using a process of inductive highlighting and coding of relevant themes for each broad topic area or general theme *(Bertrand et al., 1992; Fonteyn et al., 2008; Krueger, 1994)*, and exemplary quotes identified. Eight domains and 29 themes emerged from the initial analysis and were compiled into an initial coding manual. The themes were subsequently compressed into five domains and 18 final themes using an iterative process involving multiple sorting and refinement of themes. All transcripts were reviewed and analyzed by the study investigator.

Case study interview guide

Through qualitative assessment Santa Clara County's (SCC) sexual and reproductive health policy was thoroughly examined. The domains, questions and applicable theories outlined in *Table 3* were applied during the key informant interviews with county experts involved in the policy process.

Table 3. Case study interview domains, questions and applicable theories

Domain	Questions	Applicable Theories
Policy Formation • Problem • Solution • Political climate • Problem definition • Agenda setting	**Please explain to the best of your knowledge, how your county's policy to prevent STDs and pregnancy/fathering a child was developed.** • (*Problem*) How and why was foster youths' sexual and reproductive health prioritized for policy development? • (*Problem and Actors*) How if at all, did personal views influence policy development? • (*Problem definition*) Please explain to the best of your knowledge, if you recall a particular event or story in your county or the media that may have prompted the development of the policy in your county? • (*Problem, Solution and Politics*) What factors were barriers to policy formation? • (*Policy window*) How much, if at all, did timing significantly influence the policy development process?	• Kingdon's (1984) adapted Garbage Can Model • Baumgartner & Jones (1991 and 2009) • Stone (2002)

Venues and Policy Actors • Venues • Policy actors • Goals and objectives • Joint action • Political context	**Please explain if any influential groups of stakeholders significantly influenced the policy development process?** • (*Venues and Actors*) Who were the primary individuals (or organizations) involved in development of this policy? What were their roles in policy formation? • (*Agendas and Constraints*) What were their individual and/or shared goals and agendas? • (*Joint action*) Did the various stakeholders work together to develop the policy? • (*Venues*) What type of debate or compromise, if any, was necessary for policy development? • (*New venues and Actors*) Please explain if any new stakeholders emerged, and significantly influenced or inhibited the policy development process? What was their unique role and agenda?	• Baumgartner & Jones (1991 and 2009) • Pressman and Wildavsky (1984)
Policy Implementation • Goals and objectives • Top-down approach • Bottom-up approach • Political context • Clearance points	**Please explain to the best of your knowledge how the policy was implemented following policy development and formalization.** • *(Central actors*) Who were the primary administrators and decision makers involved in policy implementation? What were their role(s) in the implementation process? • (*Local actors*) Who were the primary child welfare staff involved in policy implementation? What were their role(s) in the implementation process? • (*Goals and objectives*) What were the shared implementation goals and objectives? • (*Political context*) How did local politics influence the implementation process? • (*Constraints*) What factors were barriers to implementation? • (*Clearance points*) What was the implementation process and approximate timeline?	• Sabatier (1986) • Hjern (1982) • Pressman and Wildavsy (1984)

Methods Section II: California statewide assessment of county sexual & reproductive health practices for foster youth

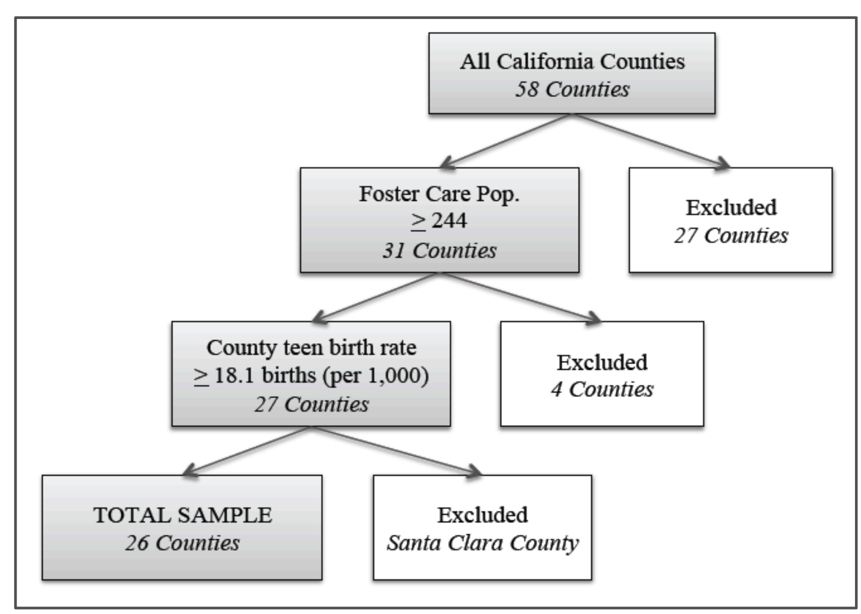
To address policy shortcomings and begin to tackle opportunities to strengthen the sexual and reproductive health of all foster youth in California through policy solutions, it was necessary to conduct an examination of the policy environment across the state. *Research Questions II(a) and II(b)* guided the examination of current policies across a sample of California counties through a document review of public records and policy documents available online through county departments of family and children's services. Additionally, a county level survey was developed to extract additional policy and procedural information via a web-based survey. Finally, brief interviews with knowledgeable county individuals were conducted to assess key issues related to policy formation and implementation. This included an exploration of the policy environments and examination of policy practices that inhibit or facilitate policy formation. The Institutional

Review Board of the University of California Berkeley approved the following study protocol and recruitment methods.

County selection

The sampled counties included counties with a total foster care population (2010) greater than 244 children and youth. Counties with populations below this value were believed to have youth populations too small to adequately reflect on the sexual and reproductive health needs, rights, services, and education of foster youth. From this sample, counties with teen birth rates greater than 18.1 births (per 1,000) were also included. It should be noted that the teen birth rates are for all county teens (15 to 19 years), and do not represent data for foster youth only. Based on these criteria, 26 counties were targeted for participation (excluding Santa Clara County) (*Figure 5*).

Figure 5. Statewide assessment selection criteria



County level characteristics were collected for the sampled counties to describe each county based on the following additional domains: race and ethnicity of foster youth, geographic locations, county politics, and participation in the California Connected by 25 initiative. The sampled counties included those with foster care populations ranging from 18,883 to 244 children and youth and county teen birth rates ranging from 56.2 to 18.1 (per 1,000). Seven were categorized as Democratic, three split Democratic/Republican and 15 Republican. See *Appendix II and Appendix III* for a more detailed description of the characteristics of the sampled counties.

Study participant sampling and recruitment

Purposeful sampling was used to identify one to two child welfare representatives from each target county who were knowledgeable about the sexual and reproductive health of foster youth.

This was accomplished by first conducting a web-based search of county Social Services Agency websites to obtain publically available contact information for high-level administrators (i.e. Directors, Associate Directors, Division Managers), program managers and social work supervisors. These individuals were contacted via telephone and email. The high-level administrators were provided with a description of the study and asked to participate in the web-based survey and expert interviews. In cases where the administrator did not believe that he/she was the most knowledgeable on this topic, they were asked to identify a child welfare representative with relevant insight and knowledge about the sexual and reproductive health of foster youth in their county. The subsequent representatives were also contacted via telephone and email and asked to participate in the study. In several cases identifying the most knowledgeable and appropriate study participant was a lengthy process. Study participants ultimately included directors, program managers, social work supervisors, public health nurses, and ILP coordinators.

Twenty individuals representing 17 counties contributed to the qualitative examination of sexual and reproductive health policies and procedures. In three cases, more than two individuals were identified for a particular county. County participants asked that both individuals participate in the study to provide a greater breadth and depth of responses. Methods for reconciling disparate web-based survey responses are discussed below.

Document review

A document review of public records and policy documents available online through county departments of social services was conducted for each of the 26 counties included in the statewide assessment sample and also for Santa Clara County (27 total county websites reviewed). The online search was performed prior to conducting the county surveys and interviews. Search terms included the individual county name along with "policy," "practices," and/or "administrative guides." The primary websites examined included county departments of family and children's services, social services, and health and human services.

Policy comparison

Two counties, Los Angeles and Santa Clara, were found to have publically available sexual and reproductive health policies pertaining to foster youth (*Table 4*). These policies were stand-alone policies that outlined department procedures, critical issues, guidelines, and stakeholder responsibilities (i.e. social workers, caregivers, and/or youth) with respect to issues of youth sexuality, reproductive health, pregnancy, and teen parenting. Santa Clara County DFCS also posted two Standing Orders pertaining to the health of foster youth. Additionally, during the expert interview for Kings County, the participating child welfare representative provided procedural documents related to the sexual and reproductive health of foster youth. It should be noted that the policy information for Kings County was not in the form of a stand-alone policy, but rather policy elements contained in other existing policies. A detailed comparison of the policy and procedural information obtained from Santa Clara County, Los Angeles County, and King County is summarized in *Appendix IV*.

Table 4. County policy documents

County	Title	Date	Description
Los Angeles County	Procedural Guide 0600-507.10 "Youth Development: Reproductive Health"	Effective date 12/21/11	Included in Los Angeles County's online DCFS Policy resources. The guide was part of the Child Welfare Services Handbook, under the Health Care section 0600-000. Other supplemental resources included the following: • Reproductive health and parenting resources for teens in L.A. County • Funding resources guide • Child care and development resources for pregnant and parenting teens • Booklet-guide for pregnant and parenting teens • Community family counseling programs
Santa Clara County	Procedural Guide 15.3 "Reproductive Health"	Last Updated 1/20/11	Included in Santa Clara County's online DFCS Policies & Procedures. Guide 15.3 was found in online Handbook 15: Health Care. Other supplemental resources included the following: • Standing Court Order on reproductive health • Title X – Public Health Services Act • California minor consent laws • Standing Court Order on ordinary health
Santa Clara County	Standing Court Order on Reproductive Health	Filed 12/15/10	Court legal document outlining the reproductive health information, services, and resources that all court involved youth should receive. Includes legal basis for these providing these services.
Santa Clara County	Standing Court Order on Ordinary Health	Filed 7/11/12	Court legal document outlining the ordinary medical, mental health, and dental treatment for juvenile justice and dependent children and youth in temporary and out-of-home placement.
Kings County	*Policy excerpts*		• Adolescent Health Care California Law • Disclosure of information and dangerous propensities to foster parents • Kings County Human Services Agency Child's Personal Rights

Web-based survey protocol

Upon consent to participate in the study, all study participants received a link to a confidential online survey administered through Survey Monkey©. The survey included five demographic and nine content questions. The content questions examined current county sexual and reproductive health practices outlined in the *Statewide Assessment Interview Guide* detailed below. Study subjects were asked to complete the online survey prior to the interview to allow the study investigator to review the findings and potentially tailor the subsequent interview. Specifically, if a particular county indicated that they had a formal sexual and reproductive health policy for foster youth, additional questions regarding the content of that policy and the policy formation process were discussed during the interview.

As noted above, there were three cases where there were multiple study participants for a particular county. In situations where there were incongruent survey responses among participants, these questions and corresponding responses were discussed during the interview with both study participants to gain clarification and to reach consensus.

Expert interview protocol

Following completion of the web-based survey, all consenting study participants were again asked to participate in the individual expert interviews. The interviews were conducted via telephone, and designed to last approximately 15-20 minutes. The interviews included open-ended questions and prompts that were used to increase the breadth and depth of responses and to allow participants the opportunity to express, in an unrestricted manner, experiences and insights.

In cases where there were multiple study participants for a particular county, the interviews were conducted at a time that was convenient for both participants to participate together. The interview questions assessed current policy practices related to policy formation. These questions and the applicable theories are outlined in the *Statewide Assessment Interview Guide* detailed below. All interviews were audiotaped and transcribed verbatim and reviewed for accuracy by the study investigator and a research assistant.

Qualitative theme analysis

Qualitative analysis was conducted using *NVivo©* software. The software was primarily used to input, organize, and code data. *NVivo©* was additionally used to identify potential relationships and general themes. Manual transcript-based theme analysis was subsequently conducted, using a process of inductive highlighting and coding of relevant themes for each broad topic area or general theme *(Bertrand et al., 1992; Fonteyn et al., 2008; Krueger, 1994)*, and exemplary quotes identified. Emergent themes from the initial analysis were compiled into an initial coding manual. The themes were then compressed into final themes using an iterative process involving multiple sorting and refinement of themes. All transcripts were reviewed and analyzed by the study investigator.

Statewide assessment interview guide

The statewide assessment includes both a web-based survey and expert interviews. *Table 5* and *Table 6* below provide an overview of the scope and content of the questions included in both the web-based survey and the expert interviews. The complete *Statewide Assessment Interview Guide* is found in *Appendix V.*

The web-based survey was designed to examine current practices to address the sexual and reproductive health needs, rights, services, and education for foster youth. Existing county sexual and reproductive health policies (Santa Clara and Los Angeles) were used as a guide to assess the below domains. Conversely, the expert interviews examined policy practices. The areas outlined below were selected to explore factors related to past, current or future policy formation. The below topics were developed by applying the policy theories noted below. Additionally,

topics deemed significant following the Santa Clara County cases study of policy formation were also studied in this analysis.

Table 5. Statewide assessment: Web-based survey domains and measures

Domains	Measures to assess current county sexual and reproductive health practices
Current practices	• Current sexual and reproductive health services for foster youth
Awareness and training	• Child welfare staff awareness of sexual and reproductive health information and services for foster youth • Training for child welfare professionals, foster parents/caregivers, foster youth
Roles and responsibilities	• Identification of individuals primarily responsible for discussing sexual and reproductive health services with foster youth
Data and monitoring	• Collection of process or outcome data
Policy	• Presence or absence of a formal sexual and reproductive health policy for foster youth o Clarity of the policy o Inclusion of minor confidentiality and consent laws in the policy o Requirement to include sexual and reproductive health information in court reports

Table 6. Statewide assessment: Expert interview domains, questions and applicable theories

Domain	Interview questions to assess policy practices	Applicable Theories
Policy Practices • Problem • Solution • Political climate • Problem definition	• (*Problem*) How is the issue of teen pregnancy, childbearing, and/or sexually transmitted diseases a problem among foster youth in your county? • (*Problem*) To what extent do you believe that the sexual and reproductive health needs of foster youth are being met in your county? • **(***Problem***)** How is this issue prioritized among other issues and services for foster youth? • (*Problem, Solution and Politics*) What are the most difficult barriers to more effectively helping foster youth prevent pregnancy and STDs? • (*Problem*) How comfortable are caseworkers in discussing this issues with foster youth? • (*Problem*) From your perspective, how influential are personal biases during discussions with youth on this topic?	• Kingdon's (1984) adapted Garbage Can Model • Baumgartner & Jones (1991 and 2009) • Stone (2002)

Venues and Policy Actors
 	
• Venues
• Policy actors
• Joint action
• Political context
	• (*Venues*) Are there currently any agencies, community-based organizations (CBOs), and/or individuals in your county that are involved in addressing this topic among foster youth?
	  o (*Venues*) If so which organizations are involved?
	  o (*Joint action*) What collaborative efforts are currently or have in the past taking place?
	• **(***Venues***)** Have any influential coalitions of stakeholders formed as a result of the collaboration?
	  o (*Actors*) Who has been primarily responsible for leading the collaborative efforts?
	  o (*Actors*) Who has been responsible for establishing the agenda?
	• (*Actors*) How involved are dependency and juvenile court judges in this issue?
		• Baumgartner & Jones (1991 and 2009)

Possible Policy Formation • Problem • Solution • Political climate • Problem definition • Agenda setting	• (*Problem definition*) From your perspective, would your county benefit from a sexual and reproductive health policy for foster youth? Why or why not? • (*Solution*) Has your county attempted to develop a policy to explicitly address the sexual and reproductive health of foster youth? If so, why or why not? • **(***Problem, Solution and Politics***)** Based on your perception, what is the key factor preventing policy formation in your county? • (*Problem, Solution and Politics*) If your county was to develop a policy regarding this topic, from your perspective, what would be the single most important agency, individual, or reason why this policy could be developed in your county?	• Kingdon's (1984) adapted Garbage Can Model • Baumgartner & Jones (1991 and 2009) • Stone (2002)

CHAPTER 5: Santa Clara County Case Study Results

The Santa Cara County (SCC) case study provides a basis for better understanding of one county's policy story. This section aims to answer the following research question: How does one county's policy formation process and history, implementation status and stakeholder experiences map to theoretical frameworks for policymaking? The data sources for this analysis included expert interviews with policy stakeholders and a review of supplemental documents obtained from study participants.

Domain 1. Policy formation process and history

Domain 1 outlines SCC's sexual and reproductive health policy formation process and history. This domain illustrates key factors associated with agenda setting, which helped elevate this issue to the point of policy change. Specifically described are problem definition among stakeholders and how evidence highlighted the sexual and reproductive health needs of foster youth, prompting key leaders in SCC to mobilize a larger stakeholder group to engage in collective action.

Theme 1a. County stakeholders are aware of the impact of pregnancy, childbearing, and STIs on the lives of court-involved youth.

All of the interviewed stakeholders from both county agencies and community-based organizations were aware of the immediate and long-term impact of pregnancy, early childbearing, and STIs among court-involved youth. Department of Family and Children's Services (DFCS) perceived a growing prevalence of pregnant and parenting foster youth, and an ever-growing need for placement options and independent housing for teen parents. Medical providers and community stakeholders working in the sexual and reproductive health field also identified foster and incarcerated youth as populations of concern—youth in need of greater targeted services and support.

> *Pregnancy rates and childbirth rates for our young populations in SCC continue to creep up to the point that we feel very uncomfortable with the numbers of young people who are getting pregnant and having 1, 2, 3 children before their early 20's, and so I think we were all really concerned.* –County stakeholder

> *Housing becomes a challenge when you have a pregnant or parenting [teen]…we know from those types of placement options what our numbers were…and that we were exceeding our placement capabilities. So [we] started at least doing the tracking of those [placements], noting that we were continuing to need to add further placements to support this population, and that it wasn't staying stable. If anything every six months we were increasing the number of placement options that we need available.* –County stakeholder

Dependency and juvenile justice judges similarly identified youth sexual and reproductive health as an important area of concern from the court perspective. One judge noted that there is a cycle

that occurs when kids don't have parents to help them navigate through these issues. Foster youth who have likely experienced significant trauma and neglect are in many ways expected to function as adults and make adult decisions. From the judge's perspective, most are too developmentally and emotionally immature to make healthy decisions alone. Many youth are at risk of following the paths of their parents and their parents' parents in terms of substance abuse and other risk factors. They clearly identified youth sexual and reproductive health as a fundamental issue that significantly impacts youth outcomes and long-term trajectories.

> *I noticed a lot of trends…that caused me grave concern. The most devastating reality was that I had very young girls 13, 14 and 15 coming to court pregnant. These were girls that I, the system, had raised from six or seven years of age. I thought to myself, we took these children from [their] parents because we said that they were not fit, and now the State as a parent, had let these precious children get pregnant.* –Judge

> *Children having children is not the best course of action. And I know that nobody was doing that for our kids, because talking about sexuality and reproductive health is a very difficult thing to talk about in a court setting and it is embarrassing for the individual… How have we served this child if under our nose she ends up pregnant at 12, 13, 14, 15, or 16...it was happening all of the time.* –Judge

> *What I want is to prevent pregnancies. I want to prevent second pregnancies if there is a first. I want young adolescents to be responsible. If they're parenting I want the child to be healthy and to get all of the services possible. Want… healthier kids. Maybe that is the goal. And of course I want to make sure that kids understand the health risks of sexual activity and take precautions, and that ultimately that the probation department and the social workers gets to a point of having…being able to comfortably talk about these issues with kids. I think that is not a given, because it is not a given with me. I am not sure that I know how to comfortably do it.* –Judge

Theme 1b. Prominent national organizations provide key evidence regarding the risks of teen and unplanned pregnancy for court involved youth to an influential audience of juvenile and family court judges

In 2009 two SCC dependency and juvenile justice judges attended a conference hosted by The National Campaign to Prevent Teen and Unplanned Pregnancy (National Campaign) and the National Council of Juvenile and Family Court Judges (NCJFCJ). The aim was to raise awareness of the high rates of teen pregnancy and childbearing among children in the child welfare system, and help juvenile and family court judges understand their role in teen pregnancy prevention among this population. While the SCC judges continually saw the impact of pregnancy, childbearing, and STIs among the youth in their county, the evidence presented at the conference validated what they were seeing in their courts and highlighted the issue from a national perspective. The conference also gave them insight into what other judges and counties were doing across the county. They left the conference not only with tangible resources that could be shared with stakeholders in their county, but also with a greater desire to take action in their own county.

> *I attended The National Campaign's seminar at an All-Sites Meeting for the National Council of Juvenile and Family Court Judges Model Courts in October 2009. We brought back literature published by The National Campaign and distributed it to all eight of the Juvenile Justice and Juvenile Dependency Court Judges. We held a joint meeting and agreed that our second most important cross over issue…was the issue of reproductive health. We were especially taken with the statistics on STI's and foster youth.* –Judge

In addition to attending the conference, the judges also cited SCC's *Dependency Model Court* designation as a factor that facilitated awareness and capacity to address this issue from the bench. This distinction awarded to them by the NCJFCJ afforded them increased access to resources, technical assistance, and supporting infrastructure to design and implement court- and agency-based changes that promote better delivery of services to court-involved families and children. With this distinction came the ability to attend strategic national conferences such as the one in collaboration with the National Campaign.

Theme 1c. Juvenile court judges increasingly request information regarding court-involved youths' sexual and reproductive health be included in court reports

Prior to policy formation, no policies or practices were in place to formally stipulate what sexual and reproductive health information could or could not be included in reports to the court. County stakeholders noted that judges both from the juvenile dependency and juvenile justice courts increasingly asked for youth sexual and reproductive health information to be included in court reports. These initial requests were challenging for social workers and probation officers charged with supplying sensitive information about youth in court reports, since they were unsure what information was allowable given youth rights to privacy and confidentiality.

> *[Judges] wanted to really identify what resources were available in the community, and find out if they can access services for our populations. I think that for them, they were seeing it through the court lens, in terms of what they were getting in their reports or not getting in their reports…As part of the Welfare and Institutions code, their obligation is to look at the child's best interest…they really saw that reproductive health was part of that assessment and how they were getting information on that.* –County stakeholder

From the judges' perspectives they felt that they needed a more comprehensive picture of the health and well-being of each child that came through their court. They not only wanted to know what resources were available community-wide so they could ensure that youth were linked to appropriate services and resources, but they also wanted to ensure that the sexual and reproductive needs of every child was addressed in some manner. Additionally, they wanted to know that each youth had a conversation with a trusted adult about his/her needs and options, and they wanted documentation in court reports that that conversation took place.

> *I want to have a sense of the global picture of what we are doing with these kids. So we have agreed that on a quarterly basis…that the judges will get a report about how many minors are pregnant, how many minors have been referred to various services, how many minors have participated in the various programs…Plus individual information in the reports that comes to me in the*

court, generally I felt that my duty as a judge was to make sure that the systems were addressing it [reproductive health]. –Judge

We get reports and [if] part of it mentions the fact that the minor is pregnant or one of the minors is dating. To me that is trigger. Immediately when I see dating I order reproductive services because I want to prevent pregnancy and if they are pregnant or they have a child and they are parenting, I think we have an obligation to prevent the second pregnancy. Because we are talking about kids having kids and that really creates long terms problems in terms of health and well-being for those kids. –Judge

Theme 1d. Juvenile court judges assemble diverse group of key stakeholders for participation in a countywide task force

In December of 2009, the two juvenile court judges invited a group of key county stakeholders to participate in a newly convened Reproductive Health and Safety Task Force for SCC's juvenile court. The judges, through their role as respected and influential leaders in the county, were able to convene a diverse and impressive group of stakeholders to address the sexual and reproductive health of court-involved youth. Stakeholders from social services, DFCS, probation, juvenile hall, mental health, the courts, the medical community, and a host of community-based organizations participated. Participation grew from 20 individuals to over 35 over the course of a year. The goal of the task force was to ensure that all court-involved youth in SCC receive the "education, information and access that they need to increase their chances at success in life by delaying first pregnancy and by staying free from sexually transmitted infections."

I think that when the judges call a meeting people show up. But I think there was also natural interest. I think we all kind of knew that this was an area that we probably need to be paying attention to. –County stakeholder

One of the great things about being a Judge, if you call a meeting people will come…It always amazes me, it is just…one of things that a judge can do. People who might not be focused on things yet or ready for it, if you call a meeting people will come. In this case they came and that task force really grew, and people got really invested in it. –Judge

Interviewed stakeholders overwhelmingly credited the judges for assembling the task force, since they were perceived to have the needed influence to convene a large group of stakeholders. While this was at the forefront of peoples' minds, most felt that without the push from the courts it is unlikely that the policy would have moved forward the way it did.

It was the judges…they started it they kept it going. If they…let's say I had been the one to start this task force, no one would have shown up. That is the reality…here is something when a judge…judges in this case…creates a task force and you are invited… you go, even though you are not mandated to be there. I give them a lot of credit…they brought all of the people that they thought had something to do with it [foster youth sexual and reproductive health] to the table. –County stakeholder

The court was running it [the task force] and [they] brought everybody to the table. I don't think that if you did it on a volunteer basis, if we sent out an email,

> *hey guys what do you think? The fact that the court said we are doing this, send somebody [from your organization to the task force meetings]…that was very powerful.* –County stakeholder

The task force was instrumental in fostering greater awareness and collaborative engagement among stakeholders. Prior to formation of the task force, some organizations and agencies had a history of existing partnerships, yet few had engaged in collaborative efforts of this scale. As the stakeholders came to the table, many realized that they were unaware of the work that others were doing in the community, and vice versa. Thus, at a basic level, the task force facilitated inter-agency information sharing.

> *You are working with the same kids. You have no idea what they [other agencies] are doing. In a way of sorts…what the judges did by bringing all of these people together, at least for that one snapshot in time, people heard what other people were doing.* –County stakeholder

> *[The judges] brought together…convened the reproductive health task force, which really brought together lots of different stakeholders from the juvenile justice and foster care side to really look at teen and unplanned pregnancies...to see what was happening in our courts. What kinds of information they were getting, what the services were that existed, and just to get an idea of what was happening.* –County stakeholder

The task force generated considerable energy and enthusiasm around this issue from the stakeholders at the table. Many saw this as an opportunity to bring an important topic to the forefront of peoples' minds, and take action to change the current system. For some stakeholders, the task force helped to elevate this issue within their departments and agencies. DFCS credited involvement in the task force with pushing their department to examine existing procedures, and take the next steps to developing a countywide sexual and reproductive health policy for foster youth. As a result of the task force formation DFCS and probation representatives broke off to form independent workgroups to examine policy formation through their respective departments.

> *It was impressive the number of people…that they [the judges] got around the table. So I kind of thought of it as an opportunity to get a topic that we all care about here and deal with all of the time, to sort of influence how other people were thinking about it and thinking of dealing with it. I am glad that it happened and I was sort of impressed that it happened, but it is also sort of like, why did it take so long. And maybe we are still ahead of other places in that we actually addressed it.* –County stakeholder

> *I noticed though that this was one of those times when there was a lot of listening. There was a lot of people sitting back and taking notes and wow…it really appeared to me that this really was one of those areas where there was that intrinsic interest by a lot of parties and people were sitting up and taking note.* –County stakeholder

> *It was the right time, all of the right players had come together, and so you had the judges bringing everybody to the table it kind of got everybody on the same page, everybody talking, and knowing that something had to be done. So then*

people were much more willing to move forward and take it to the next step. –
County stakeholder

Domain 2. Policy implementation and experiences

After the juvenile court judged convened the Reproductive Health and Safety Task Force, the group was charged with increasing court involved youths' access to education, information and services to promote their sexual and reproductive health. *Domain 2* highlights collective efforts to develop and implement procedures that more clearly defined how participating county agencies and community organizations would meet youth needs. This domain also includes the overarching policy goals and key issues researched and debated during the policy formation process.

The following themes pertain to two policies that were developed during SCC's policy formation process. First was the Standing Order that outlined a standard level of sexual and reproductive health information, services and support for which all court-involved youth were entitled through the court system. It included the legal basis for providing these resources to youth, and gave DFCS social workers and probation officers the authority to provide access to information and care. The second policy was an internal DFCS policy documenting social worker, caregiver, and youth roles and responsibilities. While the probation department explored developing their own internal policy, their policy is still in the development phase.

Theme 2a. A primary policy goal was to increase awareness regarding the content and sources of sexual and reproductive health information that youth receive

The stakeholders in the task force agreed that it was important that all court-involved youth receive the necessary information to address their sexual and reproductive health needs, and make healthier and more informed decisions. There was concern that youth did not have access to the information regarding all of the services and resources that were available to them. This was largely considered a primary access barrier for youth.

> *We agreed in concept on the vision and mission of taking on the development of a protocol to ensure that our youth are well informed, empowered and had access to whatever they needed to carry out the choices that they made around reproductive health, education and access were the operative words.* –Judge

> *I think that initially throughout most of it, a lot of the focus was really doing an assessment, an overall assessment of what was happening and getting a clearer picture and understanding. I am looking at the initial agendas, which really had report backs from all different stakeholders about what was happening in their agencies. How we identified all of their programs and services, resources, and what the gaps are.* –County stakeholder

Several stakeholders believed that many non-medical providers were unaware of the services and resources available to youth. Additionally, most stakeholders were unsure how youth routinely obtained information about sexual and reproductive health issues. They all agreed that is was

necessary to get a clear picture of what services and resources are available to youth, and how and from whom they should receive this information. DFCS and probation supervisors wanted to ensure that frontline social workers and probation officers all had the information necessary to have discussions with youth and provide them with relevant information and external referrals.

Theme 2b. Protection of youth rights to privacy and confidentiality was an important policy goal.

Prior to policy formation of the task force, social workers reported increasing requests from juvenile court judges for sexual and reproductive health information to be included in the court reports. While the judges had valid justification for requesting this information, task force members wanted to ensure that developed policies protected youth rights to privacy and confidentiality. Interviewed stakeholders noted that there was considerable discussion of the content and scope of information to be included in court reports. County Legal council was instrumental in ensuring that youth rights were well defined within the parameters of the law. The health and safety code was used as a foundation for outlining youth rights.

> *What we had was a long discussion…what about the minor for example, that doesn't want their parents to know they are pregnant. It turns out that they have a right to keep it from their parents. California has a lot of overlapping laws that protect all of this reproductive health information, so what we concluded was, if the minor does not want to disclose we won't. They have a right to keep it. Most of our minors actually don't…they discuss it pretty openly.* –Judge

> *We quoted the health and safety code…researched issues to find out what rights do kids have…If a kid who is living with their parents can get an abortion without telling their parents, why does our court have to ok a kid getting an abortion? If these are women's rights, then legally we need to make sure kids in foster care have the same rights, and their right to privacy is protected just like anybody else. We went through the statues…we went through the codes.* –County stakeholder

Among stakeholders actively involved in drafting DFCS's policy and the court's Standing Order, there was the perception that they had to balance youth rights with requests from the judges for information to be included in the court reports. One stakeholder thought that the judges acquiesced when it came to the amount of information that could be included in the court report. It was this stakeholder's perception that the judges wanted more information to help them address specific youth needs.

> *Because they stand in the shoes of the parent they feel like they need to know this information. They feel like the need to know this information if you are making a placement. Shouldn't the foster mother know that the kid in her care is pregnant? Shouldn't we make sure that they get the medical care they are supposed to get?* —County stakeholder

> *The position that we took legally, which was ultimately adopted by the group was…we will tell you in our report we've provided information, but we are not going to tell you the A, B, C's of it. We are not going to tell you she is pregnant unless she gives us permission to tell you. It pretty much says it in the standing order. All youth are entitled to privacy concerning their reproductive health. No*

reference should be made in court reports regarding private, protected reproductive health choices without the consent of the youth. So it all boils down to a good social work to get the youth release information. And I think that is where the court is a little bit frustrated. —County stakeholder

Theme 2c. The task force discussed the content and scope of sexual and reproductive health discussions with youth

One of the primary issues discussed and debated by task force stakeholders was the content and scope of discussions that non-medical service providers (i.e. social workers and probation officers) should be having with youth. Despite lengthy discussions regarding this issue there was overall agreement and eventual consensus among stakeholders regarding the nature of discussions with youth. Stakeholders viewed access to accurate and reliable information from trusted adults as an important component to youth making well-informed and healthy decisions regarding their sexual and reproductive health. DFCS and probation professionals felt that it was their responsibility and mandate to ensure that youth have discussions about their sexual and reproductive health with a trusted adult even if their service providers do not personally provide this information.

I think there were definitely some conflicts in how do we address this, how do we do that…Although there were some differences of opinion on what needed to happen, obviously this is one of those areas there are some strong opinions upon that continuum of what you could do, or what you couldn't. But it wasn't those where there were polar opposites and we didn't come to agreement…we were able…to have everything out on the table to sort through it all, and then at the end of the day come up with compromise and agreement. –County stakeholder

It was more personal kind of differences in how much do we make available, how much do we ensue that they have access…what should we be doing. It was definitely the more liberal view of those things, like full access; give them everything that was definitely the preponderance of what was in the room. It could have been those that differed in the opinion, held more quite, or didn't speak out as much. So it could have just appeared that there was compromise on that. And it also again, you never know in those circumstances, in my opinion when it is being led by the bench officers…not a lot of people will speak up or against when it is being led by a judge…let alone two judges. –County stakeholder

DFCS along with their collaborative workgroup, created a more general sexual and reproductive health policy that stressed information and options for youth rather than a more prescriptive teen pregnancy prevention message. It was determined that the policy stipulated social workers ensure that discussions happen with youth and provide them with the options and resource necessary to make well informed decisions and access needed resources. If the discussions went beyond the knowledge or comfort level of the social worker, it was his/her responsibility to make sure that youth be connected with other individuals or community resources.

We were working very hard to make sure that our policy made it very clear that's not for us to tell them, you should go get an abortion, or you should make sure

that you don't get an abortion, or whatever your own personal view is that you are providing information so that the youth makes what is her/his own personal decision. –County stakeholder

This is just a matter access to reproductive health. It is not a pregnancy prevention launch. And that was the harder step, we had to pull out of the equation to make it non-controversial and move it forward. So I think now we will be revisiting how do we really drive some pregnancy prevention, and driving down our numbers and really supporting those that do have children and do go down that path. –County stakeholder

Theme 2d. Role definition was debated with respect to who should be having discussions with youth.

Members of the task force extensively discussed who were the most appropriate individuals to have discussions with youth. A few stakeholders questioned whether non-medical providers have the necessary expertise to have technical and sensitive discussions with youth about their sexual and reproductive health. Others believed that discussions of sensitive topics should be conducted with social workers or probation officers of the same gender. Others felt that based on their experience these were not significant concerns. Despite the reservations the task force members believed that it was important for a trusted adult to have initial discussions with youth to provide resource information and options. In this case it was determined that social workers and probation officers are key contacts for youth, and often an important gateway to other more specialized services and resources and referrals.

What if it was a male social worker having a conversation with a female, and could that young female feel comfortable having that conversation, how would we utilize our public health nurses that we have on site in the absence of those conversations? Is it more appropriate for some caregivers to have it [the conversation with youth], what notification should go back to the parent if any? Kind of those discussions went on for months and months on the development of policies and procedures, and what is going to happen. –County stakeholder

They are still police and I don't think that having health stuff and conversations about major life decisions is necessarily their role, but as a social worker you can argue that they could have a conversation like that. I'm not sure social workers should, or feel comfortable, or be forced to have a conversation about specific types of birth control and medications and prescriptions that you should go ask your doctor about this…It becomes a little more…gray. –County stakeholder

While this topic largely fell into the realm of social worker roles and responsibilities, a formal DFCS policy would place greater structure and clarity around their discussions with foster youth, which was largely requested by department social workers. For probation officers on the other hand, there was greater push back from probation officers who did not feel comfortable with having these types of conversations. There was a perception that youth sexual and reproductive health was not their business. Addressing this issue could be perceived by youth as harassment, particularly if the discussion was with a probation officer of differing gender. Officers also felt

that they should focus on addressing the most pressing issues related to a youth's incarceration—reasons that contributed to the lack of prioritization of this issue among probation officers.

Despite reluctance on the part of some probation officers to address this issue with incarcerated youth, the SCC probation department and the field as a whole are undergoing a cultural shift. Probation administrators now believe that youth sexual and reproductive health is an important issue that should be addressed through their department. They cited a growing cross over in the probation field, which now views counseling with youth as a natural extension of a probation officer's work. Instead of simply addressing the reason for incarceration through behavior modification, they are now functioning to some degree as counselors, teachers, and social workers that address the root causes of behavior.

> *As the number of sexual crimes and issues increases, particularly among younger youth, it is increasingly importing to address sexual and reproductive health issues. Previously, sexual related behaviors were immediately criminalized. If officers had a better understanding of the issues that are driving the behaviors, they could work to handle some issues at the community level, rather than automatically entering the child in the system. This would be a better thing since they are still youth.* –County stakeholder

To make this cultural shift, probation administrators have had to convey to officers that their role extends beyond just making referrals—a sentiment shared by juvenile judges as well. The goal for SCC is to bring all of the probation officers to the same level. To do this, they recognize that officers will need additional training and support to fulfill these duties. Through education probation administrators hope to help all probation officers understand that providing sexual and reproductive health support to youth is an important part of their work, to achiever the larger goal of promoting overall youth well-being.

> *My goal is that I want every probation officer dealing with every kid to address their reproductive health needs, whether it is just a conversation about pregnancy and birth control, options for pregnant and parenting kids, [or] service…I just see that it has to be [this way]. Just as we address educational issues [and] psychotropic medication needs [with every kid], we should [also] be addressing it [reproductive health].* –Judge

Theme 2e. Exclusion of personal biases during discussions with youth was a key issue discussed during policy formation

The issue of personal biases influencing discussions with youth was perceived by all stakeholders to be a key issue for consideration during the policy formation process. Stakeholders worried how the personal biases (i.e. beliefs and values concerning birth control, abortion, etc.) of providers might inappropriately effect youth decisions with respect to their sexual and reproductive health.

DFCS created a policy that specifically included anti-bias language, explicitly discouraging social workers from including personal biases in discussions with foster youth. In addition to incorporating this language in the written policy, DFCS also collaborated with Planned Parenthood to conduct sexual and reproductive health trainings for social workers that focused on issues of personal biases.

> *We tried to, in writing the policies and procedures for DFCS…to carefully draft the language to make sure that we were not giving people an ability to use their own biases. We really went over the language time and time again, to make sure it was very clear about what was expected…this was not about putting our views about it on the kids. This was about giving the kids information so could make their decisions about they are going to do.* –County stakeholder

> *We really had Planned Parenthood at the table with us, doing a lot of education and support…how do we have these conversations? A lot of concerns around the social workers having these conversations, and their own conscious or subconscious biases coming into play during those conversations.* –County stakeholder

The issue of youth sexual and reproductive health was widely perceived to be a difficult and uncomfortable topic to discuss with youth. Stakeholders noted that some social workers feel inadequately trained to discuss issues related to sexual and reproductive health with court-involved youth. Training for social workers was a key provision included in DFCS's policy. They stipulated training for social workers, foster parents and caregivers, and foster youth as an important aspect of addressing youth sexual and reproductive health. Approximately one year following the onset of the policy process they partnered with Planned Parenthood Mar Monte to train all of the social workers in their department. A key element to these training was how to exclude personal biases during discussions with youth.

> *They did trainings specifically for the social workers about how do you have these conversations with these kids, because it is an uncomfortable topic for a lot of people. I think the department really did a nice job to try to make sure as much as you can, rule out people's [biases]. I've heard comments that people have made to kids that I think, "Oh my goodness, they shouldn't have done that." But that was before we had any policies…we had all heard these different stories about situations that had happened and we were working very hard to make sure that our policy made it very clear that's not for us to tell them, "You should go get an abortion, or you should make sure that you don't get an abortion, or whatever your own personal view is that you are providing information so that the youth makes what is her/his own personal decision.* –County stakeholder

Domain 3. Factors influential in policy formation and implementation

During the policy process participating stakeholders identified several key facilitating factors. *Domain 3* highlights the factors identified by stakeholders as being most influential during the agenda-setting phase, while others were instrumental during implementation. Without the presence of many of these factors, the policy process might not have progressed at the same rate, or succeeded at all.

Theme 3a. Professional mandates play a role in motivating stakeholder involvement and action

DFCS stakeholders cited an overarching departmental mandate to promote the health and well-being of children and youth in foster care, which logically can be inferred to include adolescent sexual and reproductive health. Prior to policy formation in this area, there were no explicit mandates to address this issue with foster youth.

The participating dependency and juvenile justice judges cited a professional mandate, which compelled them to address the sexual and reproductive health of court-involved youth. The judges, as well as most stakeholders agreed that "for both dependents and wards of the court, the juvenile court has a *parens patriae* interest in promoting and preserving the health and welfare" of the minors in their care. For many youth in the foster care and juvenile justice systems, sexual and reproductive health information and support were inaccessible or non-existent. As such, the judges believed they have a duty and responsibility to address this issue and better promote the health and well-being of these children, and prevent unplanned pregnancies whenever possible.

> *The juvenile court has a parens patriae interest in promoting and preserving the health and welfare of those minors. The court is responsible for providing care that as nearly possible is equivalent to that of a parent and is required pursuant to Welfare and Institutions Code sections 362 and 727 to make any and all reasonable orders for the care, supervision, custody, conduct, maintenance and support of the child, including medical treatment.* – RHSTF Report

> *As dependency court judges we stand in the shoes of the parent so clearly this is our job. I also think that this issue needs to be bundled up with child well-being. Safety, permanency and well-being is the Child Welfare mandate, however, we have rarely if ever really tackled the definition and measurement of child well-being. Foster youth getting though high school without getting pregnant should be a key indicator of child well-being for our foster youth.*—Judge

> *Oh, this is something that we really do need to do for our kids. We are raising these kids. This is information that every kid needs…all they know really is what they learn on the streets. So you know, we really should be providing more than that to these kids who were are at such risk for becoming pregnant at such young age.* – County stakeholder

The participating juvenile court judges also cited a professional responsibility to serve as leaders in the community who work collaboratively with any number of community agencies and individuals to address the needs of court-involved children and youth in their county. The participating SCC judges subscribe to a therapeutic court model, which is a more holistic approach to rehabilitation and behavior modification.

> *Juvenile judges are different than other judges. The traditional judge lives in a world where they are, by and large, neutral and impartial, just call the laws and strikes and that is it. Now the therapeutic court goes a little bit further, where you are part of a team and you kind of trying to work as the leader of a team. Well, juvenile even goes beyond that, because the code specifically says that we are unique in that we have a responsibility to have oversight of our system and to advocate for juveniles to make sure that they have the resources and services they*

need to fill their needs and the needs of their families. And we have an obligation to build relationships with people in the community…to foster working together to knock down the walls and build the bridges for the benefit and best interest of the kids. So that is a big job…we have build up a lot of relationships. –Judge

As with any other initiative to improve systems outcomes, the Judge should be leading the reform both on and off the Bench. The Judge can do this by convening meetings, speaking out at community forums and speaking directly to stakeholder professionals at their regularly scheduled meetings. In other words, the Judge should go to the community. The Judge should also suggest legislative solutions where necessary. –Judge

Theme 3b. County stakeholders cite involvement by juvenile court judges at the most influential factor in the policy formation process

Judges were widely cited as the driving force responsible for setting the policy agenda and pushing the policy formation process forward. Prior to the formation of the task force, prioritization of the sexual and reproductive health of court-involved youth varied across stakeholders. While it was broadly identified as an important issue with significant implications in the lives of these youth, there were differences among stakeholder organizations in terms of how the issue was currently prioritized in relation to other issues and services for court-involved youth.

We definitely have had to prioritize it because the judges make it a priority. It was one of those things that was definitely pushed down, with some pressure from the court. But I think that there was also a lot of energy and enthusiasm around this from all of the stakeholders. –County stakeholder

They [judges] really wanted to see something different…and it just hadn't really come to the forefront. I think it had been on peoples' radars, but that [task force] kind of pushed it to the forefront. –County stakeholder

From the probation department's perspective, incarcerated youth have multiple issues that they face on a daily basis. While high rates of pregnancy were pervasive among youth in their care, their sexual and reproductive health was simply not highlighted or prioritized, because it was not deemed critical in comparison to immediate issues of behavior management. For example, if the youth was incarcerated for issues related to gangs or drugs, these issues trumped reproductive health from the perspective of probation officers.

They have too many other things. It is not their priority. Health is not their priority. That is not how they are judged. –County stakeholder

Despite the overall praise for the task force, a few stakeholders worried about sustainability and the task force's overall impact on the sexual and reproductive health of court-involved youth. From their perspective, the collaboration was forced on the part of the judges. Regardless of their skepticism, they believed that addressing this issue among court-involved youth was critical and inter-agency networking and sharing was important for ensuring youth needs are better met.

> *There have always been groups that have been working in this field, obviously, but I think they forced collaboration and it will be interesting to see how that collaboration continues without them sort of driving it.* –County stakeholder

Theme 3c. An existing culture of collaboration facilitated policy implementation

Several stakeholders noted that existing familiarity with other task force stakeholders eased the collaborative policy process. While all of the stakeholders were familiar with the other task force members as a result of attendance in other workgroups, collaboratives and task forces, few had directly engaged in collective efforts of this scope. It was also mentioned that policy implementation was facilitated by an overall culture of collaboration across Santa Clara County. This perceived culture of collaboration facilitated collective action around this issue and necessary systems and policy change.

> *There is a reason that you are here looking at us. It is not just about reproductive health. We have a culture of working together in this county that is really unique. It has always been a collaborative county at all levels of government. It is not unusual when I am out of state or out of county at different things there is a recognition that Santa Clara County seems to be able to get things done. And so I think we can overstate our role as judges in this whole process. We are just a piece of it. The people that came together are people who have spent lifetimes collaboratively working on all kinds of issues. I think it would be very unfair to say this only happened because of judicial leadership… I would be surprised if the working relationship [elsewhere] for example, between probation and juvenile judges is anywhere as good as ours here. –Judge*

> *Well, yes, it is hard work. I think you can't kid yourself. Trying to change systems, first of all, it can only be done collaboratively. I've always believed that you can try order people to do things, but you're not going to get the buy in, you are going to get the resistance. The best way to change the culture and get things done is to have everybody at the buy in level, at the same level of understanding, appreciation of the need. So that is a lot of work. It takes a lot of work. –Judge*

> *Last time I counted I think I was on 45 committees, organizations and task forces. She has the same number…It is really hard to move the football down the field. To get the room to do it can be really hard sometimes. It can take time and energy, so it can be a challenge. If you really appreciate the collaborative approach you can't be naive about it. It can be difficult. –Judge*

Theme 3d. Allocation of resources and lead staff to oversee the policy process was integral to DFCS's successful policy formation and implementation

High-level DFCS administrators including the director, deputy director, and supervisors were involved in the task force from the beginning. They attended early task force meetings and contributed to the policy formation process. Early in the process they also allocated key staff time and resources to lead and support this effort internally. The designated individuals were assigned to oversee the process and ensure proper implementation.

Mandating our social workers to go and get trained and do this. It was, at the time, one of my main job responsibilities, in terms of participating and getting everything rolled out, and working with Planned Parenthood. So they allocated the resources for it. –County stakeholder

Then of course within our structure we had managers, supervisors, and the whole triage structure. So there was a good group of about 20 that met for regular time period etching out what those procedures were going to be. –County stakeholder

The lead staff persons were also involved in forming and overseeing the internal DFCS workgroup, which was responsible for developing their department's policy. The internal workgroup included a very diverse group of child welfare stakeholders, including youth, who created the detailed policy. The workgroup was instrumental in helping to facilitate the development of policy or procedures that was deemed to be complicated and potentially controversial. After the workgroup developed the policy, then it was sent to multiple clearance committees for feedback and approval prior to implementation. Some of these approval points included the social workers' union and several levels of department staff.

We convened an internal work group, to look at what it was that we were doing or not doing. And so that is really how our policies and procedures developed, the impetus for the larger conversations was the community task force, but then it was really about convening here internally with our stakeholders and our people to start to put together the policies and procedures. –County stakeholder

So that net was cast to a lot of our case carrying workers that had older youth, 14 or older, on their case loads. Child advocates were at the table. A lot of our community providers that dealt with population…those from our group homes, those from our FFA's (foster family agencies), those from county license foster homes. We asked for other caregivers at the tables, we asked youth representatives at the table, Planned Parenthood was really there as more as an expert for us in that field, and they sent 2-3 people throughout the process to make sure we were linked in with what was out there, and curriculum what's going on. –County stakeholder

The allocation of key resources and lead staff time was facilitated though buy-in from both administrative decision makers and central level actors. Essential to gaining this buy-in is involvement from passionate leaders who can generate large-scale support from local actors responsible for implementation. However, maintaining necessary buy-in over time can be challenging and a threat to program sustainability.

Generally policy development, yes, you have someone who is passionate about it, or because of the work becomes passionate about it really pushing forward some sort of agenda. The question is really how do you get everybody to also be passionate about it and really see the need and value in it, to the point that everyone is embracing it and taking it on…it is a challenge. —County stakeholder

Theme 3e. DFCS policy passes departmental clearance committees with minimal resistance

After the DFCS workgroup completed the written policy, the policy had to go through a department approval process, which included several clearance committees. From the onset of

the policy process County Legal Council was extensively involved in the policy formation process, ensuring that the policy address youth rights and met legal standards. Additionally, DFCS managers and supervisors, and representatives from the Social Services Agency provided input and approval.

The policy was also presented to the social work union to determine if the policy posed a workload issue. This clearance committee had the potential to stall the policy implementation process if the union representatives viewed the policy as a significant increase to social worker workload. Despite input from multiple stakeholders and decision makers, there was surprisingly little protest to the policy and its proposed implementation. During the policy process several participating stakeholders worried that there would be push back from various child welfare stakeholders, particularly those concerned with the impact of a new mandate and additional workload demands on an already strained workforce.

> *There is always bureaucracy, it is always hard to…with social work unions, there is another step before you can mandate social workers to do anything. What is the workload impact of this? And so the unions are always a player in terms of whenever asking social workers to do anything new or different or adding new forms that social workers have to do or requirements to what they have to do, you have to vet it through the union to some extent.* —County stakeholder

> *Really the lack of resources…anytime you ask government workers to do more work, you have the chance that there will be push back from the unions or staffing organizations. However, in this case people were really onboard to do this, and there was less push back.* —County stakeholder

Domain 4. Policy barriers and next steps

At the time of the interviews, the court's Standing Order and DFCS's internal policies had been implemented for approximately one year. As stakeholders discussed the policy formation and implementation process they were able to step back and reflect upon barriers they encountered and next steps.

Theme 4a. Lack of departmental infrastructure and resources impede DFCS's evaluation efforts

One of the greatest challenges cited by stakeholders was the ability to evaluate policy implementation and the impact of the policy among social workers and youth. DFCS stakeholders acknowledge that it is difficult to assess implementation among a large number of social workers with varying levels of role specialization. Social workers in Santa Clara County either work directly with adolescent populations or not at all, making conversations about youth sexual and reproductive health either routine or non-existent. However, with the shift to extended foster care through AB12, newly created specialized units now specifically address the needs of young adults ages 17 ½ to 21 years.

The primary barrier is that you have hundreds of social workers, so how do you really…consistency, getting people to do things consistently. Being able to really know that across the board implementation is happening. I think that is the biggest challenge. —County stakeholder

Nothing is being tracked. I don't think as an agency we have figured out how to do that, because you have some social workers who never have to deal with that because they have all young kids on their caseloads. You have some social workers who have a caseload full of teenagers and are dealing with it all of the time and who are much more skilled. But there is not one point of information, where things get filtered. —County stakeholder

At the time of the interview, approximately one-year post policy implementation, DFCS was not tracking outcomes due to a lack of infrastructure and resources. DFCS stakeholders cited a need for a strategy for assessing the need for ongoing training and implementation challenges, and a system for collecting and tracking outcome data. Work force shortages and high turnover contribute to these challenges, since the safety and protection of youth is often a higher priority. Training efforts are also challenging, because high staff turnover requires continual training for which resources are often limited.

Administratively we have been down on our work force for those who do that [data tracking], so one of those things that you deal with the crisis and you deal with the safety and protection first. So [this is] one of those things that starts to pile up. Our to-do list for that is really large and so that has been a barrier. You need to develop some resources to evaluate what you are doing and make sure it is really working and to keep it in the forefront as well as other competing priorities, again that have more to do with safety and risk and this is one of those that, is there some safety and risk...possibly, but it doesn't rise to the level of safety and risk you may not put it there. —County stakeholder

Despite the lack of a current evaluation strategy, DFCS recognizes the importance of examining the long-term implications to help assess how youth are faring. The department would like to have a better system for monitoring the services youth receive so they can ensure that youth are able to access necessary information and services, and that they are having discussions about their sexual and reproductive health with a trusted adult. DFCS would also like to ensure consistent implementation among social workers, which would create a system of quality assurance and staff accountability.

Definitely be important to know how many of our kids are really parenting, male and female… Are they accessing information? I would love to know that every one of our kids, 12 and older has been to some sort of appointment, training, where they have been really given a thorough conversation around their reproductive health rights and information…we really want to know if we are making an impact. —County stakeholder

It is one of those policies and procedures that we would like to revisit and do some surveys, or take a pulse from the staff level, supervisor level, manager level. How well do you think we are doing on this? Do you think staff are struggling with this, so it will rippled effect into unit meetings, to bureau meetings, and then depending on how that feedback come back then we may make some strategic

> *decisions. Do we need to have some regular ongoing training that is occurring, do we need to rethink through any of the policies and procedures and what is happening? Or do we think we've got it and for the general mass we can ensure that it is occurring and those supervisors who have identified potential staff that are struggling with it more are putting in safeguards of how it is going to occur?* —County stakeholder

Theme 4b. Stakeholders recognize long-term sustainability challenges

Several stakeholders noted issues related to long-term policy sustainability. Though the DFCS policy was a formal mandate approved by multiple internal clearance committees, other competing mandates and workforce pressures affect policy implementation. Given the many demands of social workers and the need to address the most pressing issues facing youth in foster care, prioritization of sexual and reproductive health was still challenging.

> *Even though you do the training and you promote it, you also have, in all honestly, lot of things [mandates] that come and go. Lots of new mandates, lots of new initiatives, how things [will] stay over time is hard to know.* —County stakeholder

One stakeholder discussed the potential disconnect that can result between the policies and the realities of implementation. The notion that the "people on the ground" have a different view of how easily or challenging policies are to implement given the day-to-day constraints facing individuals who work directly with youth. Given these issues, this stakeholder recommended bringing as much reality into the policymaking process as possible. Because the judges were so influential in the policymaking process from what was described as a top down approach, this stakeholder worried that there was not enough consideration of the realities of implementation discussed during the policy formation process.

> *When you make policy sometimes it just doesn't fit the reality. I am not saying that the reality is perfect. The reality may need to change to fit the policy. It is just interesting that when people make policies things seem so clear…And then when you talk to the people who are charged with doing it, it is a totally different world because they are like, how am I supposed to do this, this, this, and this? I can't do that, or I don't have any idea.* –County stakeholder

Theme 4c. Unexpected outcomes following task force formation and policy implementation

Participating stakeholders cited several unexpected policy outcomes. Several stakeholders noted that as a result of the task force, new collaborations between agencies and organizations formed, where they had not existed in the past. While many groups were aware of the other stakeholders and agencies serving court-involved youth, they had not engaged in collaborative efforts in the past.

DFCS saw increased integration of sexual and reproductive health topics into multiple program areas and services for foster youth.

> *And I would have to say that as a result of all of this, reproductive health has just been integrated into more things…even in our parent orientation now, we talk to*

our parents who come into the system about reproductive health, and the conversations that social workers are going to be having with their kids. Encouraging them to have those conversations with their kids. Every year our ILP (Independent Living Program) has a month of the year that really focuses on reproductive health. So it is just integrated into a lot more things now as a result of the [policy] focus. —County stakeholder

As a result of policy formation efforts in SCC, stakeholders have received requests from other counties and organizations for information on the task force and the collaboration to promote the sexual and reproductive health of court involved youth. One of the juvenile court judges received calls from other counties to share what they had done in SCC and the policy mandates. This judge would love to see the growing interest evolve into a state-level mandate that would ideally ensure greater youth access to needed information and resources across the state.

As a result of this collaboration, Planned Parenthood received a grant to conduct the sexual and reproductive health trainings for DFCS social workers, caregivers, and foster youth. The grant was instrumental in Planned Parenthood being able to reach these populations. Without funding, Planned Parenthood felt that it would be very challenging to commit the necessary resources to train these target groups. Planned Parenthood also received requests from neighboring counties for similar resources, trainings and technical assistance. They were both surprised and pleased to receive such publicity and request for collaboration.

I will say though, as a result of what we did with SCC the word has spread and we've done trainings now with San Mateo County as well as Alameda County around this exact thing. So people are getting wind of it and are excited about it. They don't have a formalized process like SCC, but San Mateo County has reached out to us as well as Alameda to try to do professional trainings. —County stakeholder

Theme 4d. Post policy implementation and next steps

Participating stakeholders were asked to reflect on the policy implementation process and next steps. Several stakeholders noted that they need to continue their efforts to promote youth sexual and reproductive health and long-term well-being for court involved youth in SCC. They recognized that the developed policies and procedures might not be enough to ensure that youth needs are appropriately and adequately met.

Before you can claim success…[for] any kind of program or issue you are going to tackle, it has to be institutionalized and become a part of your culture. So that if I drop off the map tomorrow and [name] drops off the map and gets promoted to something else, and [name] get sent by mental health…it doesn't all fall apart and everybody doesn't forget about the issue and it has become apart of what we do. –Judge

I think it is going to be work in progress for us. We definitely have formal policies and procedures, we've had several trainings for staff and for caregivers, and for youth, but I think this is definitely going to be one of those areas that is going to be a work in progress for us because it comes with a lot of taboo subjects and a lot of biases. –County stakeholder

In addition to developing an evaluation strategy and tracking system for youth outcomes, DFCS aims to conduct ongoing trainings with social workers and all foster youth. They also plan and place a greater emphasis on pregnancy prevention.

> *Really evaluating, are we doing this well, where are we still stuck, how will we ensure the ongoing training for this, and then…how are we going to work to change the numbers? So are we going to really work to really do some of the pregnancy prevention? This [policy] is just a matter of access to reproductive health. It is not a pregnancy prevention launch, and that was the harder step, we had to pull out of the equation to make it non-controversial and move it forward. So I think now we will be revisiting how do we really drive some pregnancy prevention, and driving down our numbers and really supporting those that do have children and do go down that path…and possibly even pregnancy prevention after the first one so that we don't have 2, 3 young children with a very young mother and father.* —County stakeholder

Some stakeholders perceived that there was an abrupt end to the task force efforts with no clear next steps. One stakeholder was frustrated because despite the development of the DFCS policy and the Standing Order for the courts, the issue is ongoing and the problem persists.

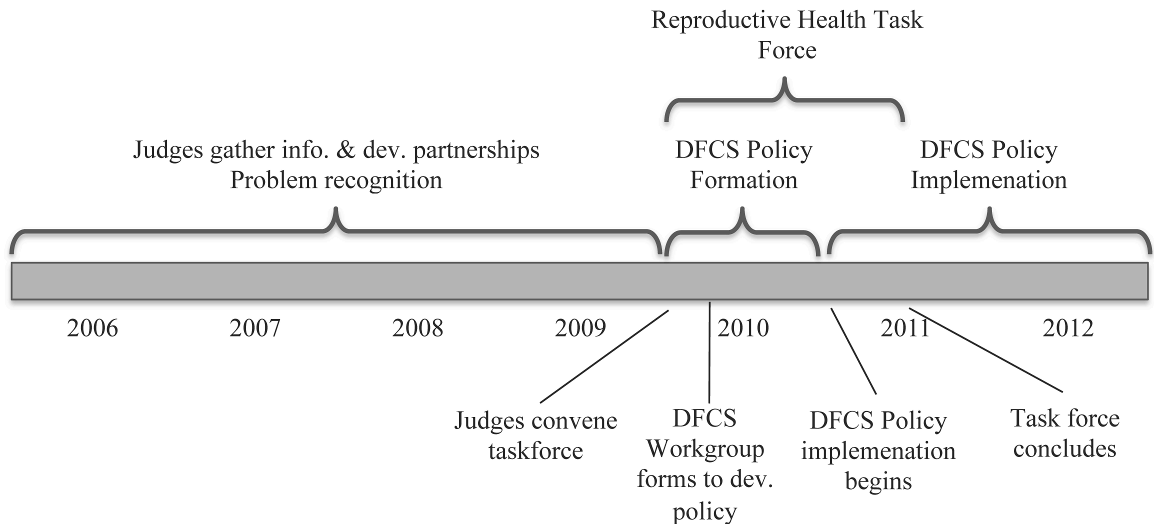
> *Now things change all of the time so I don't know if they are still doing what they were doing, they don't know if I am still doing. Who knows? Again another reason why I felt like, the task force has a limited function and role and time course, but there is something that I think should be standing. We have a document [Task Force Final Report] that is now a year old. Is it still relevant?…Did it do anything?* —County stakeholder

Santa Clara County policy formation and implementation timeline

The policy formation process in Santa Clara begin in 2006, when the juvenile court judges began to recognize and define the sexual and reproductive health needs of court-involved youth (*Figure 6*). During this time they began to speak with key stakeholders (i.e. Legal Council) and develop partnerships with external stakeholders (i.e. Planned Parenthood). The judges convened the Reproductive Health Task Force in early 2010 and Department of Family and Children's Services (DFCS) stakeholders formed an internal workgroup to examine policy formation through their department by April 2010. Both the task force members and participants from the internal workgroup provided extensive feedback on the developed policy. A summary of DFCS's policy can be found in *Appendix IV*.

DFCS implemented their policy in early 2011, with approval from department administrators, legal council and the social worker's union. Implementation kicked off with sexual and reproductive health trainings for social workers and key staff provided by Planned Parenthood Mar Monte. At the time of data collection for the present study, DFCS's policy had been in place for approximately one year. No evaluation of the policy from the perspective of child welfare staff, foster parents/caregivers and/or foster youth has been conducted to date.

Figure 6. Santa Clara County policy formation and implementation timeline



Santa Clara County case study summation

The case study of Santa Clara County (SCC), demonstrates how one county's policy formation process and history, implementation status and stakeholder experiences map to the theoretical frameworks for policymaking. Kingdon's adapted Garbage Can model provides an appropriate framework for examining how the three policy streams (problems, policy solutions, and politics) converged to allow for problem definition and agenda setting to occur *(Kingdon, 1984)*.

In this case, the participating stakeholders sufficiently recognized the key issues and implications of early pregnancy and childbearing among foster youth. Stakeholders also identified attainable solutions to address youth needs. These solutions included 1) the judges' roles as leaders and conveners, 2) the active involvement of multiple stakeholders in developing and implementing a sexual and reproductive health policy for youth, and 3) the central role of DCFS staff and social workers in addressing the sexual and reproductive health issues and needs of foster youth. Finally, the political conditions were primed for addressing this issue as demonstrated by the involvement of key national organizations (NCJFCJ and National Campaign) in increasing awareness about the unique needs of court involved youth and highlighting the unique role of juvenile court judges. Through their involvement with these influential national organizations the judges brought new issue framing back to their county, which provided greater overall legitimacy to this issue. Through the policy process, the judges functioned as highly influential policy entrepreneurs that were instrumental in coupling the three policy streams at an opportune time, pushing the issue of foster youth sexual and reproductive health to a local policy agenda.

The implementation activities described in this case study demonstrate key aspects of both the top-down and bottom-up approaches to policy implementation. The early implementation process denotes strong top-down influence, as policy decision makers were influential in developing and mandating adherence to a new DFCS reproductive health policy for foster youth *(Sabatier, 2007)*. However, the overall implementation process described in this case study

largely demonstrates a bottom-up approach. Though the policy clarified the social workers' roles and responsibilities there was wide discretion in terms of how individual social workers interpreted and carried out the policy mandates. There were also no evaluation measures established to monitor and assess policy implementation. We can only speculate how existing contextual factors and constraints influenced the implementation process, and the degree to which local level actors (i.e. social workers) adapted the policy and to what extent implementation deviated from what policymakers intended.

While the policy process SCC closely links to the framework outlined by Kingdon, these data do not indicate whether the key policy factors and barriers demonstrate a unique case of policy making or whether these factors could be relevant in other counties with similar policy goals. Specifically, how much was the role and influence of the juvenile court judges necessary for policy formation? Many stakeholders noted that policy formation would likely not have occurred in the same manner, or at all in the absence of judicial involvement and prioritization? What is the likelihood that other counties can demonstrate similar judicial involvement? Alternatively, if not the judges, then whom? What other policy entrepreneurs can similarly influence the agenda setting process?

To investigate these and other issues related to policy formation and implementation, a similar assessment was conducted across a sample of California counties. Based on the findings from the SCC case study, the role of potential policy entrepreneurs was investigated. Counties were asked to reflect on the role of juvenile court judges in overseeing the care and well-being of foster youth. In the absence of judicial involvement, counties were asked to reflect on the role and influence of other prominent policy actors and stakeholder groups. Additionally, for counties with developed policies, an examination of the factors relevant to policy implementation was also explored to identify the applicable implementation approach and potential complexity surrounding the implementation process. Since the effectiveness of the SCC is still open to question, it was important to examine how other counties with policies evaluate policy implementation and associated program effectiveness.

CHAPTER 6: California Statewide Assessment Results

The California statewide assessment study aimed to answer the subsequent research questions: 1) What are the county practices in California related to foster youth sexual and reproductive health needs, rights, services, and education? and 2) What are the key issues relevant to county-level sexual and reproductive health policy practices among a sample of California counties? The data sources and methods for this analysis included the following: 1) a document review of public records and policy documents available online through county departments of family and children's services, 2) a web-based survey to extract additional policy and procedural information, and 3) expert interviews with knowledgeable county individuals to assess policy practices.

County and participant characteristics

County characteristics

Of California's 58 counties, 26 met the sampling criteria (excluding Santa Clara County) outlined in *Chapter 4: Methods.* Representatives from 17 counties (65% response rate) agreed to participate in both the online survey and the telephone interview (17 counties had one individual participate; three counties had two individuals jointly participate; for a total of 20 individuals across 17 counties). Of the nine non-participating counties: seven attempted to identify a suitable representative but ultimately did not participate; one declined to participate, and one did not respond at all. A more detailed description of the sampled counties is found in *Appendix III*.

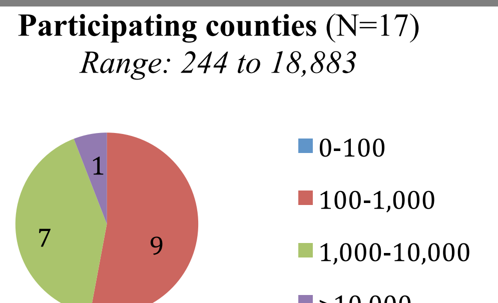
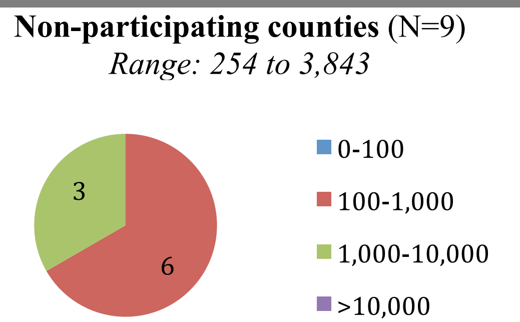
Table 7 outlines the key characteristics for both participating and non-participating counties. County profiles for the total county foster care population were comparable for participating and non-participating counties; the majority of counties had populations that ranged from 100-1,000 foster care children and youth. A higher proportion of participating counties had teen birth rates that ranged from 40-60 births (per 1,000) as compared to birth rates of 0-20 and 20-40 births per 1,000. Participating counties were more likely to have foster care populations that were predominantly Hispanic/Latino (compared to white and black populations). A larger portion of counties designated as Republican participated compared to counties not participating.

California is divided into 11 geographic regions. However, only seven of these regions were represented among the participating counties. Six out of 17 participating counties were from the San Joaquin Valley. While four Bay Area counties were targeted, only one county from this region participated (Alameda County). Finally, among the sampled counties (N=26) two (not including Santa Clara County) were CC25 (California Connected by 25) initiative members and three were not.

Table 7. Participating and non-participating county characteristics

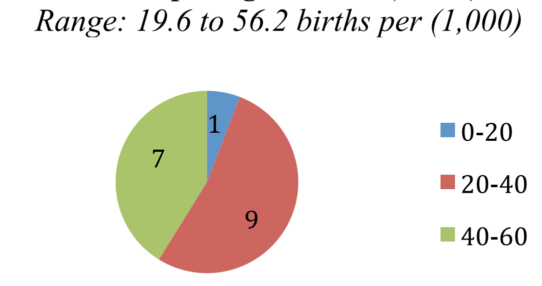
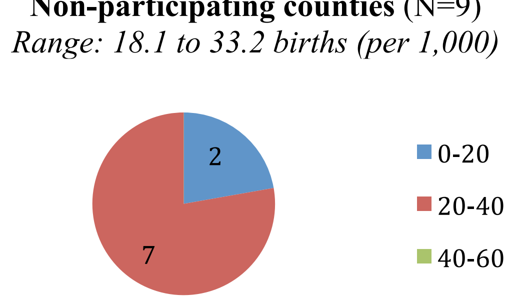
Total county foster care population (2010)[a]

Number of counties falling into one of four population categories

Participating counties (N=17) *Range: 244 to 18,883*	**Non-participating counties** (N=9) *Range: 254 to 3,843*
	

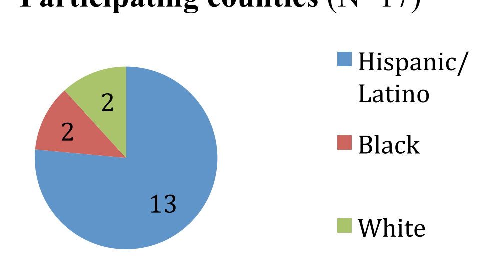
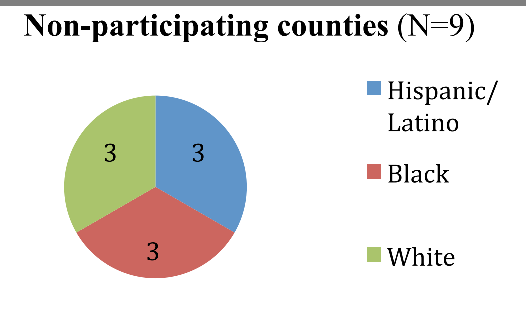
County teen birth rate (per 1000)[b]

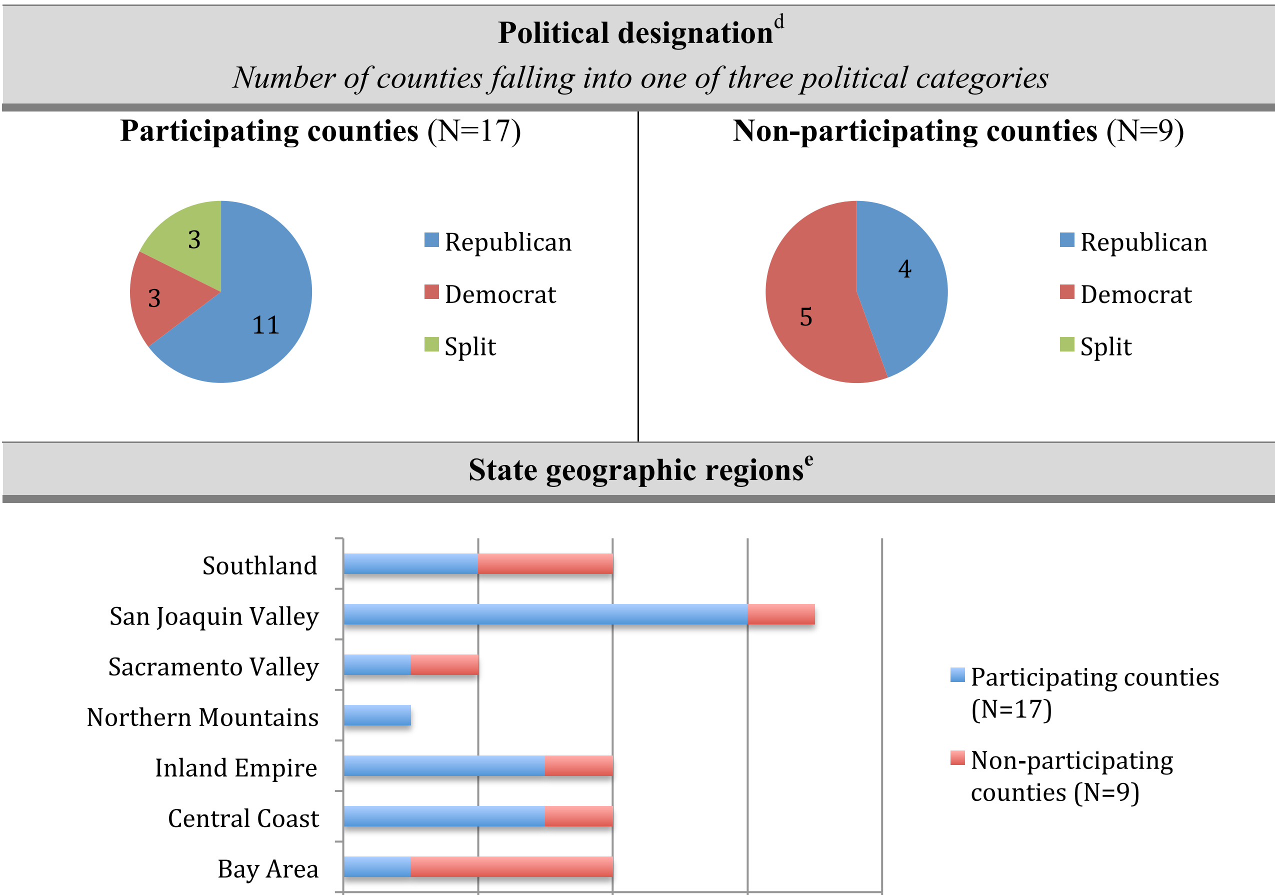
Number of counties falling into one of three teen birth rate categories

Participating counties (N=17) *Range: 19.6 to 56.2 births per (1,000)*	**Non-participating counties** (N=9) *Range: 18.1 to 33.2 births (per 1,000)*
	

Prominent race/ethnicity of children in foster care (2012)[c]

Number of counties with foster children falling into one of three prominent race/ethnicity categories

Participating counties (N=17)	**Non-participating counties** (N=9)
	



Footnotes:
[a]National Association of Counties (2012). "California." Find a County. Retrieved Aug 1, 2012, Available from http://www.naco.org/Counties/Pages/FindACounty.aspx.
[b]Constantine, N. A., P. Jerman, et al. (2012). Teen Births in California: May 2012 update. No Time for Complacency. Oakland, CA, Center for Research on Adolescent Health and Development.
[c]Child Welfare Information Gateway (2012). Foster care statistics 2010. Washington, DC, U.S. Department of Health and Human Services, Children's Bureau.
[d]County voting records were used as a proxy for the liberal and conservative nature of individual counties. Voting records from the last 10 years (1972 to 2008) were used. If the county voted democratically 6 or more years they were labeled "Dem."; 5 years exactly were labeled "split"; and 4 or fewer years were labeled "Repub." Source: Wikipedia. California County Profiles. Retrieved Aug. 1, 2012, Available from http://en.wikipedia.org/wiki/[INSERTCOUNTY],_California.
[e]The California Voter Foundation (2012). "Regional Map." California Map Series. Retrieved Aug. 1, 2012, Available from http://www.calvoter.org/voter/maps/index.html.

Study participant characteristics

Of the 20 study participants the majority of individuals were female (18) (*Table 8*). Sixteen out of 20 participants had worked in child welfare for greater than six years. The positions and titles of study participants varied considerably. They primarily consisted of foster care managers or supervisors (3 individuals), and program managers, supervisors, or directors (6 individuals). The latter group was responsible for overseeing particular department programs or initiatives. Three participants indicated that their role was specifically related to policy oversight, including issues

of policy development, management, and implementation. Two Deputy/Assistant directors of Social Services participated in the study. These central level actors provided the perspectives of key administrators and decision makers. Also of note were the two public health nurses who participated in the study and provided unique and valuable assessments of youth sexual and reproductive health from a public health perspective.

Table 8. Study participant characteristics

**Data obtained from the web-based survey*

Gender of survey participants	Years in child welfare
Female: 18; Male: 2	0-3 years: 1; 4-6 years: 3; >6 years: 16

Position/Title of Study Participants	
Position/Title	**Number of participants (N=20)**
Independent Living Program coordinator	1
Foster care social worker	3
Foster care manager/supervisor	3
Program manager/supervisor/director	6
Policy related positions: *Assist. Regional Mgr. Court & Policy; Mgr. Policy and Implementation; Oversight of Policy*	3
Deputy/Assist. Director, Social Services	2
Public health nurse	2

Domain 1. Sexual and reproductive health information, services, and support

Domain 1 illustrates the current sexual and reproductive health practices across the participating counties, including the information, services, and support that foster youth receive. Data from both the web-based survey and the expert interviews provide a snapshot of youth access to these resources across the state. This domain discusses consistencies and variations across counties, and highlights the situations in which foster youth are most likely to receive comprehensive sexual and reproductive health services. Finally, this section examines the delivery of services in the absence of mandates and the degree to which the needs of youth are currently being met.

Stakeholders from participating counties were asked in the web-based survey to indicate the current sexual and reproductive health services for foster youth. All 17 counties provided youth with referrals for resources and services. Nearly all counties included counseling and discussions with case mangers and social workers, and the Independent Living Program (ILP) as resources for youth. Less than half of the counties had programs for pregnant and parenting youth, and only two counties had programs for adolescent males. Thirty-five percent of counties offered training in sexuality or family planning for both caseworkers and foster youth. Only three counties (18%) provided training for foster parents/caregivers (*Table 9*).

A majority of participants (59%) completing the web-based survey identified social workers as primarily responsible for discussing issues of sexual and reproductive health with youth, which was followed by ILP workshops (29%). Only one program identified foster parents/caregivers, and another cited community-based organizations as being responsible. Given that social workers were largely viewed as responsible for addressing this topic with youth, only four participants (24%) reported that child welfare staff were completely aware of the content and sources of sexual and reproductive health information and services available to foster youth. The vast majority (76%) of staff appeared to be only partially aware of the available information and services (*Table 9*).

Web-based survey findings

Table 9. Foster youth access to information, services and support

	Number of Counties (%) - (N=17)
County sexual and reproductive health services	
Referrals for resources and services	17 (100%)
Counseling and discussions with social workers	16 (94%)
ILP resources	16 (94%)
Visits with public health nurses	12 (71%)
Programs for pregnant or parenting youth	8 (47%)
Training in adolescent sexuality or family planning for social workers	6 (35%)
Training in adolescent sexuality or family planning for foster youth	6 (35%)
Training in adolescent sexuality or family planning for foster parents/caregivers	3 (18%)
Programs for young men	2 (12%)
Primarily responsible for discussing issues of sexual and reproductive health with youth	
Social workers	10 (59%)
Independent Living Programs	5 (29%)
Foster Parents/Caregivers	1 (6%)
Community-based Organizations	1 (6%)
Public School System	0 (0%)

Perceived child welfare staff awareness of the content and sources of sexual and reproductive health information and services available to foster youth	
Completely Aware	4 (24%)
Partially Aware	13 (76%)
Completely Unaware	0 (0%)

Expert interview findings

Theme 1a. Child welfare professionals cite multiple sources of sexual and reproductive health information and services for foster youth

Child welfare professionals cited several different sources of sexual and reproductive health information. ILP workshops were a primary source of information for youth across counties. However, study participants noted that not all youth are eligible or able to participate in these sessions. A large number of study participants felt that foster youth were likely to receive some sexual and reproductive health information through the schools, but they could not detail when youth receive such information, how frequently, or to what extent.

Social workers were also cited as key individuals involved in providing youth with necessary resources and referrals. The frequency and degree to which social workers engaged in this topic varied considerably both across counties and within individual county departments. Counties with specialized units for adolescents, transitioning youth, and/or youth in extended foster care through AB12 were the most likely to have social workers that frequently engaged youth in conversations about their sexual and reproductive health. There was a reliance on referrals to health professionals or community organizations such as Planned Parenthood, who were perceived to have greater expertise in this area. It was largely believed that sexual and reproductive health information was and should be covered by medical professionals. Many thought youth were likely to receive information and support from physicians during clinic visits and/or through discussions with public health nurses.

> *They see the doctor…the assumption would be that the doctor handled that, or the public health nurse handles all of that rather than doing any kind of follow up*. — Policy manager

Public health nurses, in particular, were identified as key referral points and sources of technical information for both youth and social workers. Several study participants discussed more formalized partnerships with public health departments, where social workers can and do regularly refer youth to speak to a public health nurse about both general and reproductive health needs. One county had public health nurses specifically dedicated to addressing sexual and reproductive health issues with youth and social workers. Study participants noted that in some counties public health nurses are involved in teaching ILP workshops. As with social workers, there appears to be lack of clarity among public health nurses in terms of well-defined roles and responsibilities.

> *We have the nurses on staff, which is a huge thing. Because I was here in the days before we had the nurses on staff, and it's a huge improvement having them here*

> *to help us, and to be able to talk to the kids. So I think that's also an important community resource that we have.* —Public health nurse

> *The nurses are available on individual cases and we make ourselves readily available to any child…we'll go to appointments with them, we'll go to Planned Parenthood with them, we'll do individual discussions with them, well go to their family physician with them, or make arrangements for them. But, there is nothing that is formally set up. There is no policy here, or special protocol.* —Public health nurse

Theme 1b. Predominate approach to addressing youth sexual and reproductive health was case-by-case

While some study participants noted having services and referrals to services for youth, in many cases delivery of sexual and reproductive health services and resources to youth was not system-wide. Several study participants noted that their standard approach to addressing youth sexual and reproductive health is on a case-by-case basis. In lieu of a system-wide approach for all foster youth, many assess the youth's individual level of risk resulting either from past trauma or abuse, or if a social worker detects current risky behaviors. In these cases, youth are prioritized for specific sexual and reproductive health services. Multiple county representatives noted that in cases of general neglect, it was unlikely that this topic would be prioritized and addressed with youth.

> *Depending on the reason for the initial referral…for example if the referral involves a sixteen year old who's having consensual sex with a 17½ year old, of course, sexual and reproductive health would be discussed. If it's not in the emergency response referral, then it [sexual and reproductive health issues] would not be addressed.* —Policy manager

> *The only time I would see it as a priority, or the agency would see it as a priority is if for example, [if] a teen pregnancy [was] the product of a rape or crime. Or, if the teen parent has a baby then we evaluate the risk to the baby…If the minor is supposed to be registering with the public health department because they have a certain STD, then at that point it would be a priority.* —Foster care supervisor

When asked to reflect on the extent to which the sexual and reproductive health needs of foster youth are met in one's county, the vast majority cited an unmet need and noted that there is room for improvement. Some noted the need for a more comprehensive, rather than superficial approach.

Domain 2. Defining the issue of foster youth sexual and reproductive health

Domain 2 illustrates child welfare staff recognized foster youth sexual and reproductive health issues and needs, and the actions of various and influential stakeholder groups. Findings for this domain were obtained through the expert interviews.

Expert interview findings

Theme 2a. Issues associated with the sexual and reproductive health of foster youth are significant and often problematic for youth and child welfare staff

The study participants overwhelmingly identified sexual and reproductive health as a relevant issue for foster youth both while in care and following emancipation. Many participants perceived this issue to be a "huge" or "big" problem for youth. Issues that were particularly problematic included: sexual promiscuity, pregnancy, early childbearing, sexually transmitted diseases (STDs), prostitution, and trafficking of young girls for sex related activities. A few participants identified these topics as relevant and often problematic for foster youth, but noted that they actually saw few cases (i.e. childbearing or STDs) among youth in their county.

> *So the issue is huge and we have a lot of teen pregnancies we have a lot of STD issues, we often have to take our children in for treatment of gonorrhea, herpes, AIDS…we've had children with AIDS. We also have had a few human trafficking cases, prostitution, we had a federal case this past year…We've had children exploited prostituted out by their parents, so they continue to have these behaviors even in foster care.* —Deputy Director

> *We had a 12 year old pass around STDs at the junior high school, and she would go out to the truck stop…and she would prostitute out there at the truck stop. So there is a whole bunch of stuff going on here.* —Deputy Director

Child welfare staff noted that many sexual and reproductive health behaviors and outcomes are linked to other risk behaviors such as substance abuse. A few participants mentioned that drug use was a significant concern impacting youth in their county. Factors associated with youth placement in foster care (i.e. trauma, sexual abuse) and experiences while in care (i.e. lack of stability, running away) were perceived linked to youth sexual and reproductive health. Additionally, the lack of placement stability, with families and individuals invested in youth, was thought to have a very significant impact on the health and wellbeing of youth.

> *Neglect, abandonment, grief, and loss…a lot of the times the emotional issues supersede practicing safe sex and using effective methods of birth control, especially when they feel that emotional want is being met by a boyfriend, a guy, it [birth control] just goes out the window.* —Social worker

> *The primary issue with these kids is because they were sexually abused as children they typically have a drug problem. So when they start to use methamphetamines, the number one drug here in the valley, it is difficult to keep them on birth control. They just disappear and they run away. They are non-compliant, and then of course birth control is voluntary so we can't put a Norplant in them for example…we do have kids doing all of that and it is a huge issue.* —Deputy Director

Several county representatives underscored the influence of youth's desires to be loved and to have a child. Youth hope that by building their own families they can make up for their own challenging family lives and upbringing. Often the hope of creating a consistent and loving family predisposes youth to unhealthy sexual relationships that result in an unplanned pregnancy, teen births, and/or domestic violence.

> *In our population you're dealing with emotional and family dynamics that are greater than any prevention methods that the community has to offer can handle. Because you have young girls who have been neglected and abused and traumatized and they want to be loved. So when they find that guy who they think loves them, or is giving them the fantasy of love, then everything goes to the wayside because they are so vulnerable…it supersedes any of the education, planned parenting, anything that we as case workers try to address on a monthly basis when we meet with these kids.* —Social worker

> *I think one of the biggest areas is having that kid. For kids in care, if they're not in consistent placement, they haven't really made a good attachment to the care provider…They're looking for love and maybe to them what the guy is saying in that moment is enough. I think that's a huge barrier, just that consistency in their life.* —Program Supervisor

Despite the youths' often glorification of teen childbearing, child welfare staff regularly saw the realities and long term implications for parenting youth. Many vocalized their added concern for pregnancy and parenting youth already dealing with existing hardships and challenges associated with being placed in care. They recognized that for teen parents issues of housing, education, employment, and finances would now be that much harder. These youth were now forced to deal with issues of child care and the emotional and psychological stress of being young parents.

> *About five years ago I went to the ILP awards banquet… I looked around and saw...[that] two thirds of foster youth here are pregnant, and the other third were totally thinking that was the coolest thing on earth…What worried me is that it [teen childbearing] is romanticized.* —Assistant Director

> *The fact that it [early childbearing] leads to them living in a tougher financial situation…that's what makes it [their lives] even harder. They think that they'll be in a relationship and they won't have to be on cash assistance…[that] they'll be on their own…but they don't know the reality of it. More than likely they'll be on cash assistance, living in poverty. They'll have a tougher time going to school…makes it hard to go to college and get a degree...I mean, former foster youth, as it is, have it tough…and then you have another major obstacle of having a child, it's almost impossible.* —Program Director

For social workers there is the added burden of trying to find appropriate placements for teen parents and their child/children. They noted that these placements are often in short supply. While some study participants mentioned having specialized family placements with specially trained parents that can mentor the youth and provide parenting support, they still struggled with meeting the demand for this type of placement.

> *I guess, if I was to say how is the problem, I think I would think about it in terms of finding adequate placements, you know, someone that would accommodate a mother and child – not also that, but kind of act as a mentor to help them with the parenting. I don't think we have enough quality homes in that respect.* —Program manager

Finally, a general lack of responsibility among youth with respect to family planning was frustrating to child welfare professionals. They noted that even if youth receive sexual and

reproductive health information and access to services there is often low birth control utilization and compliance. Additionally, many youth were not willing to be accountable for their reproductive health; they didn't want to regularly see a doctor or nurse for STDs screenings and basic check-ups.

> *A lot of the young ladies on our caseload, they will practice birth control to a certain extent. But they will not practice safe sex, meaning they will not use condoms. That's a big issue. Then, I find that birth control falls off the importance, and then they stop taking their birth control method, whether it's the shot or pills, and then they end up pregnant*. —Social worker

> *Whether it's from a lack of training, lack of education, lack of a steady household that they come from...they don't have the parental back-up behind them…many of the girls I find are not willing to have an exam. They'll say, "ok, I'll get on some kind of birth control, but I don't want to have someone look at me down there." And they'll be sexually active, but they don't want to pursue having physical check-ups.* —Public health nurse

Theme 2b. Full scope of foster youth sexual and reproductive health is difficult to assess in the absence of tracking systems

While only a few participants indicated that they tracked sexual and reproductive health outcomes for foster youth, none knew the prevalence and/or incidence of outcomes such as teen births, STDs, and abortions. For counties with extremely high teen pregnancy rates among the general adolescent population, there was a sense that issues of teen pregnancy, childbearing, and STDs were likely greater among the foster care population. However, they couldn't be certain of the scope or magnitude of various outcomes.

> *We're not aware of all of them that are pregnant, is either because they don't know that they're pregnant, they're not reporting to their ongoing social worker…Some of our girls that are runaways, they come back pregnant…when they're about to give birth...We have a number of kids that are runaways. Some of them are prostituting or doing drugs…it's hard to get a number of those. So some of them may be pregnant, some of them may come in the later part of their pregnancy have the baby and then run away again. Every situation is different.* — Social worker

A majority of study participants specifically cited the lack of a tracking system as a barrier to fully understanding the scope of foster youth sexual and reproductive health. They noted that these data are not routinely documented due to youth rights to privacy and confidentiality. Social workers have to be very careful what information they include in official child welfare reporting systems, as much of this information is documented in court reports. In many cases, they are not aware of a pregnancy until "the birth is imminent."

> *There are kids that will access a certain clinic and because of confidentiality the clinics will service them and they're not obligated to report certain information…They could be sexually active and if something surfaces, a pregnancy or a disease and then they seek treatment without consent, because*

they're allowed to do so, and the clinics will help them. Those fly under the radar. —Foster care supervisor

Domain 3. Barriers to addressing the needs of foster youth

County child welfare professionals were asked to discuss the most difficult barriers to more effectively helping foster youth prevent unplanned pregnancy, early childbearing, and STDs. *Domain 3* discusses the predominant barriers cited by child welfare staff. Findings for this domain were obtained through the expert interviews.

Expert interview findings

Theme 3a. Many social workers are uncomfortable discussing topics of sexual and reproductive health with foster youth

Nearly all of the study participants mentioned social workers' lack of comfort having conversations about sexual and reproductive health with youth. Many believe that the comfort level with the topic largely influences the nature of the conversations between social workers and youth. With the exception of social workers from specialized units for adolescents, transitioning youth, and/or youth in extended foster care most social workers were reluctant to discuss such sensitive and controversial topics. Many perceived that youth sexual and reproductive health was covered ether on a case-by-case basis, or in a likely "superficial…preachy kind of way." Most thought that social workers were hesitant to engage youth in meaningful, thoughtful conversations, discussing issues of healthy relationships, sexuality, and motivations.

> *I don't see that we give social workers instructions, or that social workers, in general are asking questions that would cause youth to explore…why they might want to have a child, or why they might not want to address birth control…Questions like why they might be having sex with people they don't know well, or that they don't intend to be continuing in a relationship with, or where it doesn't appear that the relationship is going very well, but they're still having…unprotected sex that could lead to disease and pregnancy.*—Foster care manager

Trusting and long-lasting relationships with youth were identified as a key factor that facilitated conversations with youth. Several study participants noted youths' perceived fear of repercussions if they reveal sexual risk taking, pregnancy, etc. Youth worried that disclosure of such information could result in loss of privileges or placement, or even result in exposure of private information. Furthermore, the issue of gender discordance between social workers and youth was also cited as a barrier to having conversations with youth.

> *I still believe that, to be effective, in working with this population, you need to have a working relationship with them. They need to trust you and they need to be able to convey to you, without fear of repercussions, on these issues. And only at that point would any type of service or intervention be effective. Aside from that,*

> *it's like speaking to the wind. It goes in one ear and it comes out the other. And it surfaces and then comes out pretty aggressively.* —Foster care supervisor

> *With an adult who they respect, telling them, "wait, if you do have sex, be protected." Helping them look at their future goals, the bigger picture. I mean, we try, we hope, but we're only mandated to see these children once a month*. —Program Supervisor

Contributing to the lack of comfort among social workers was conflicting personal values and beliefs. Some study participants believed that one's personal biases regarding sexual and reproductive health behaviors might inappropriately influence youth decisions. Opposing values and beliefs were thought to result in an absence of conversations between social workers and youth. A handful of county participants cited the conservative nature of their county, and it's potential influence on discussions with social workers and available resources for youth at the school and community levels.

> *I have heard other social workers talking, not in front of kids…talking about [how] they don't believe in birth control, it's against their religion. So, they're not very supportive of that [birth control] for some of the foster youth. I've heard others say things about, they're not comfortable talking about it with the kids, so they don't really do it that much…I think that's something that should be an ongoing conversation. It's a life-changing decision when they end up getting pregnant.* —Assistant Director

> *Our conservative nature might frame that [conversations with youth]…when we talk about teen pregnancy and STD's among youth some people take the stand that abstinence is the way to go where, others take into account that children/youth are sexually active and they should have the full range of information, not just about abstinence. Surely abstinence can be a part of it, but then we should also talk to them about prevention…Conservative counties maybe lean more towards abstinence, or not have the discussion at all.* —Program Director

Several study participants noted that social workers in their county are not mandated to have conversation with foster youth about their sexual and reproductive health. They are likewise not required to document such information in their standardize reporting system or make this information available in court reports. There was a perception that discussions of this nature should be left to parents and caregivers, and not necessarily social workers. Study participants argued that many social workers relied on outside referrals to other individuals such as doctors and nurses to have those conversations with foster youth.

> *That wouldn't be my role, I don't see myself as their parent. To me, that would be the care provider. So I think that an area we feel lacking is [whether] the care providers [are] even having that conversation. I don't think the staff is comfortable talking about that, especially if you have a highly sexualized individual. You're always afraid that they are going to make allegations against you*. —Program Supervisor

> *I don't really see the social worker necessarily as the best person to do it, but if we could….we refer them to all kinds of people for all kinds of needs. If there was*

a way to refer the young person to people who could help them explore their options and make decisions, have good information to make decisions. —Foster care manager

Theme 3b. Social workers lack necessary training to discuss topics of sexual and reproductive health with foster youth

The web-based survey results presented in *Table 9* above show that only a third of counties offer training in adolescent sexual and/or family planning for social workers (65%) and foster youth (65%). Even fewer counties provided training on this topic for foster parents and caregivers (18%). The qualitative interview results echoed these findings and expounded upon the paucity of trainings across counties.

Some social workers are skilled at that and some are not...some foster parents are skilled at that and some are not. A whole lot of us avoid conversations because we don't know what to say. —Foster care manager

The primary barrier for some counties was the lack of a mandate stipulating that trainings should occur. In the case of social workers, without a mandate to attend trainings on this topic it was thought that social workers would not have an incentive to attend. While some counties highly support, and in some cases require, training for social workers and case managers, there is great freedom among staff to attend trainings that interest them. However, it was noted that social workers have a lot of competing issues and priorities that cause them to overlook the issue of youth sexual and reproductive health if it is not mandated. Workload demand among social workers has been a consistent and overarching barrier for addressing this issue with foster youth. Budget constraints were also cited as a contributing factor to training insufficiencies.

Every two years they are required to complete 40 hours of training…they are not mandated. Some of them may be strongly recommended, so it is kind of optional for those who get to go to certain trainings. They can pretty much choose which ones they want to go to. But, I mean, just looking at the various trainings, I don't honestly recall seeing a specific training around pregnancy prevention and STD's. —Program manager

The lack of sufficient training on the topic of adolescent sexual and reproductive health was seen as an obstacle to social workers comfortably and effectively initiating and facilitating conversations with foster youth. As noted above, there is a sub-set of social workers who are comfortable talking about sensitive issues with youth, but their remained an overall perception among study participants that many lack accurate information about topics related to sexual and reproductive health, particularly birth control options. More than one study participant thought that prevention of unplanned pregnancies, teen births, and STDs could be improved if social workers were knowledgeable and comfortable with these topics.

I think to a certain extent they [social workers] are comfortable, but they prefer for somebody else to do it…I would say it's probably more because they're not [comfortable], they don't want to misinform the youth…they're not confident in how much they actually know. —Public health nurse

> *If we had training geared towards this topic, it would be a more uniform information delivery, because they would know what the parameters are and what the expectation is*. —Program Director

Though lack of training for social workers was largely seen as a barrier in most counties, some study participants noted that their county offered regular trainings for social workers that included topics of sexual and reproductive health. One county noted having "à la carte training" sessions for social workers to help them have difficult conversations with foster youth. This county based their training offerings on observed need and staff requests, and cited extended foster care as the impetus for their trainings on "sexual health and sexual wellbeing."

Theme 3c. The sexual and reproductive health of foster youth is prioritized to varying degrees across counties

For many counties the sexual and reproductive health needs of foster youth were often overshadowed by other fundamental youth needs such as safety, housing, financial resources, employment, and emancipation. One study participant said that youth sexual and reproductive health often doesn't even warrant a conversation by social workers given the many other issues that are believed to take priority.

> *We need to meet their food and shelter needs and then also get them ready for employment; get them psychologically sound, whether that is via therapy and/or medication monitoring, etc. The sexual health would fall lower on that priority list*. —Policy manager

> *I think we start off with education. We always start off with: "Please graduate from high school." It's so important; that's number one…I think sexual health and family planning keeps getting pushed down further and further as a priority. Because the question is, will they need housing options, transitional housing, how will they pay for it if they don't get a job, vocational skills, get them to college. That's the push constantly. I don't know of any mandates that say we have to provide sexual health information or family planning*. —Program Supervisor

Some study participants noted that in their county priority was given to behavioral issues possibly related to children and youths' placement in foster care. This often resulted in a focus on behavior modification and counseling to ensure youth safety and placement. Also, given limited resources, some counties are only able to focus on "bare necessities" and solely address issues for which there are mandates for compliance.

> *The number one go to thing is counseling services…there may be a lack of recognition of a holistic approach. In other words, the emphasis is so much on maintaining or trying to correct behaviors with counseling that basic health care is maybe a lower priority*. —Policy manager

> *Other things are taking precedence. It's a shame. Maybe if there was more funding in the area of the prevention piece, it just seems like a lot of times we tend to be more reactive than proactive in these leaner budget times*. —ILP Coordinator

As noted above in *Theme 1b (Predominate approach to addressing youth sexual and reproductive health was case-by-case)*, some participants believe that foster youth sexual and

reproductive health is prioritized on a case-by-case basis in their county. If children or youth have a history of sexual abuse, or if they currently engage in sexual risk behaviors this issue is prioritized. In the absence of such indicators or risk, participants indicated that many social workers rely on other health professionals to address general issues of youth sexual and reproductive health.

Other county participants said this issue was an ongoing priority among child welfare staff. One county noted allocating considerable department resources (human and financial) to addressing youth needs in this area in terms of assessment of needs, clarification of resources, staff outreach, and curriculum implementation. However, there was the perception that greater prevention efforts should be taken. Study participants from other counties similarly echoed the desire for better prevention efforts. Another county viewed all foster youth needs, including sexual and reproductive health, as priorities. As such, this issue was not prioritized among other important services and resources for foster youth, rather it was given top priority along with all youth needs.

> *Whatever the kids need, they get. We don't say we are not taking this kid to family planning because [they] need to go to school. I don't know if it is because we have such a big issue, but our adolescents are a priority…if they need educational services they get the educational services, tutoring, books, computer…they get family planning, safe sex.* —Deputy Director

A study participant from one county thought that prioritization of this issue was linked to data collection systems that by necessity dictated what type of topics were covered with foster youth during routine meetings. According to this individual, youth participating in ILP complete a program survey regarding program experiences. It was the perception of this individual that the nature of the survey dictates the content of the discussions with social workers.

> *In the [ILP] survey it's not asking, "Was my reproductive health addressed by the social worker." It is asking…"Did my social worker talk to me about housing? Did my social worker refer me to food stamps? Did my social worker get my medical in place? Did my social worker help me make permanent connections? Did my social worker help with family finding?"…For the social worker when they're completing their surveys throughout the life of the case, they're not asking about reproductive health, so they're going to say, in their defense, they're focusing on the data collection*. —Social worker

Despite the lack of prioritization among participating counties, several study participants noted the importance of placing greater emphasis on this issue in the future, because "in all honesty...I don't think it is given high enough" priority.

> *As more and more information comes to us about this topic, even just speaking with you, and going to the informational sessions with our partners, I think that we will realize that we do need to make it a priority, and that making a policy is not something that is going to be tremendously hard…we can do that.* —Program Director

Domain 4. Policy formation issues

Domain 4 examines attempts at policy formation, policy formation barriers, and involvement by administrative decision makers and influential stakeholder groups. Findings for this domain were obtained from the web-based survey and the expert interviews.

Web-based survey findings

Study participants from each of the 17 counties were asked if their county currently had a formal sexual and reproductive health policy. Only three counties indicated that they had such a policy: Kings, Los Angeles, and San Luis Obispo. Nine of the 17 counties did not have a policy and five were unsure. Of the three counties with policies, one participant believed that the policy was "very clear" while participants from the other two counties perceived their policy to be "mostly clear." Only one county was routinely asked to provide sexual and reproductive health information in court reports; this county was one of the two counties with an existing formal policy. Less than half of the counties (N=7) collected sexual and reproductive health outcome data for foster youth; the remaining counties either did not collect these data (N=6) or were not sure (N=4).

Table 10. County policies and policy practices

	Number of Counties (%) (N=17)
Presence of formal sexual and reproductive health policies for foster youth	
Yes	3 (18%)
No	9 (53%)
Not Sure	5 (29%)
Routinely asked to provide information regarding youth sexual and reproductive health in court reports	
Yes	1 (6%)
No	14 (82%)
Not Sure	2 (12%)
Collection of sexual and reproductive health outcome data for foster youth	
Yes	7 (41%)
No	6 (35%)
Not Sure	4 (24%)

Expert interview findings

Theme 4a. Study participants from most counties believe that a formal sexual and reproductive health policy for foster youth will benefit the services and support that youth receive

Though most counties lacked cohesive policies, and many had not prioritized the issue due to competing issues and work force demands, nearly all participants identified the potential benefit associated with a formal policy in their county. Study participants thought that a policy would add needed clarification to social workers' roles and responsibilities, and provide greater consistency and direction. Two issues study participants believed to be particularly confusing for social workers were the questions of youth rights to privacy and confidentiality, and allowable topics for discussion with youth in the work place. It was also thought that a policy would provide greater consistency in terms of discussions and guidance for social workers, and clarity regarding what information can be included in court reports.

> *To have a policy, organizational blessing, direction, would provide consistency and direction and clear guidance for the workers. Generally that encourages them to put themselves aside and focus more on the child and the child's needs.* — Policy manager

> *Social workers did not know if they could even have a conversation with the kids…"Can I have that conversation? Or will I get in trouble for talking about sex? Will I get in trouble for using the word 'penis' and 'vagina' with kids?" So I think they were uncomfortable and afraid of getting in trouble.* —Public health

One county provided a salient example of what happens in the absence of a policy that effectively outlines social worker roles and responsibilities, and youth rights to seek reproductive health services. The below case highlights how lack of clarity regarding roles and responsibilities, coupled with conflicting values and beliefs among social workers, left considerable ambiguity regarding how to support youth-identified health needs, while also protecting a youth's right to privacy and confidentiality.

> *About a month ago…one of our kids who got pregnant for a second time…wanted an abortion…That became an emergency for us, in a way, because then it was like, ok, the foster parents can take her. Well, the foster parent was like, "No, it's against my beliefs and my values, and you know, that won't be right"…They contacted the social worker, and the social worker was like, "well I don't know what to do. Can I even take her?" Then it turns out the social worker wasn't comfortable…She spoke to the public health nurse in her area who…knows me, super-liberal, would take her…I have no problem transporting her, but we don't have anything telling us that we can or cannot transport…we did speak to a supervisor, and [he/she] said "Yes, you can transport to an abortion but she needs to schedule her own appointment"…It was a lot of uncertain roles and responsibilities…And then we ran into the issue…does she need to document that she was pregnant and she had an abortion…county council said, "No, that is private and confidential, [and] that does not get documented in any narratives or in court reports."*—Social worker

It was suggested that a mandated policy would also raise overall awareness of the issue among child welfare staff and upper management, highlighting the importance and relevance of information, services and support for foster youth. In the words of one study participant, "It would force the administration to look at that [issue] and really pay attention."

> *If you think about it, it's a cost-effective measure, because it's just like with the housing, it's cheaper to prevent on the front end than it is to pay for them on the welfare system and the healthcare system later…I think that that [a policy] might help really put it on the radar and kind of force counties to pay a little more attention to it.* —ILP Coordinator

Several study participants thought that a policy would be a good opportunity to outline and mandate trainings for social workers, foster parents/caregivers, and foster youth. As noted above, training for social workers on adolescent sexual and reproductive health was viewed as a way to increase the comfort level during discussions between social workers and youth. Topics that they felt should be included in mandated trainings included: healthy relationships, issues for bisexual and transgendered youth, mental and emotional health, safe sex, sexuality education, and guidance on initiating conversations with youth. Additionally, one county participant thought that the presence of a policy would allow for a larger emphasis on prevention, which was a goal for several counties.

> *If we had a policy that was across the board…we could train foster parents, we could train incoming social workers, and it could be an ongoing message through our independent living program. That's how I see it could drive home [the prevention message]. That way they [foster youth] get it from all spectrums as they're going through the dependency system*. —Social worker

> *We do have programs that are available for teens once they are pregnant…and what help you can get for your baby. But there really isn't anything that's out there…regarding sexuality…prevention of pregnancy and the whole responsibility of it.* —Public health nurse

Study participants from three counties questioned the utility of a formal policy. One county cited the potential challenges of workload increases and the bureaucracy that can be associated with policy implementation. Others cautioned that policies should be carefully developed and framed, in a manner that is thoughtful and not overly prescriptive.

> *When I think of the word policy, I think of labor. And I've been involved in many discussions where, we try to implement things that can be a policy, and it's just a back-and-forth thing. So I think more of implementing good practices, is probably better for us than policy. Because once you try to implement policy, they get drug out foreve*r. —Program manager

> *I'd like to see something that is very thoughtful and helps our social workers explore with young people ways to find out what their options are.* —Foster care manager

Theme 4b. External advocacy organizations and county-wide collaboratives are influential in raising awareness

Study participants from five counties mentioned involvement with other agencies, community-based organizations, and/or advocacy coalitions involved in directly or indirectly addressing the sexual and reproductive health of foster youth. Participants from two counties mentioned involvement with prominent advocacy organizations in their respective counties.

In one of the counties, the local advocacy organization was comprised of approximately 40 foster youth serving agencies that regularly come together to identify and discuss concerns for this population, with a particular focus on the needs of transition age youth. The organization has a representative that meets regularly with county officials from Children and Family Services to highlight key issues and needs for youth. In November 2010, this advocacy organization formally recommended that the county address several key issues for youth, one being the sexual and reproductive health (i.e. pregnancy and STD prevention). The county accepted their recommendation, and went on to increase ILP resources and instruction around this topic. Several child welfare staff were provided input on new procedures. The second county noted working closely with a similar local child advocacy group. This group felt strongly that the county should focus on greater reproductive health education for foster youth. This suggestion prompted the county to form a "DCFS Pregnant Teen Work Group" charged with revising and developing policies and education strategies aimed at promoting the reproductive health of foster youth.

Study participants from two separate counties highlighted involvement in local teen pregnancy/teen mom collaboratives. While these collaborative do not explicitly focus on the issues and needs of foster youth, they do address the general sexual and reproductive health needs of adolescents across the county. One county participant discussed the collaborative nature of the group and the importance of sharing information, collaborating on projects, and supporting one another's funding request and initiatives.

One study participant recounted her involvement in a regional policy committee through the County Welfare Directors Association of California. This group of representatives from seven counties regularly discusses a variety of policy issues, and shares policy ideas among one another. This committee was viewed a helpful way to support individual and collective policy issues.

> *No, we mostly steal from each other…No, we share strategies, typically, in statues or codes or regulatory directives, directives of the state, [and] things that affect everybody. Then we do bring up things that are administratively driven, so there's not a statutory requirement for something, but somebody will say, "our director wanted this or that – what do you guys have on it." Or, "What do you think about this?" We strategize on it [and] how that might work.* —Policy manager

Finally, participants from two counties cited partnerships with neighboring academic medical institutions. These institutions were instrumental supporting training. In one of the counties, the academic institution was specifically charged with developing and conducting training for social workers, out-of-home caregivers, and foster youth. Funding for these efforts came from the department's training section, and was supported by a motion from the Board of Supervisors.

Theme 4c. Policy process relies largely on upper management support and approval

Though participants from most counties acknowledged potential benefits associated with a formal sexual and reproductive health policy, study participants noted that most counties had not attempted to develop such a policy. For policy formation to occur it was widely thought that the issue needs to be prioritized and in the forefront of the minds of managers and decision makers responsible for changes in policy. Most did not see a problem raising the issue with upper management, but noted the importance of a champion to move the issue forward.

Several study participants cited a relatively clear internal process for initiating policy changes that largely involved support and approval from key department leaders, followed by training for social workers responsible for rolling out the new policy. One study participant noted that a state or federal mandate might be necessary to really raise awareness and prioritize this issue, and then it would ultimately trickle down to social workers. Others also saw roles community organizations and other county agencies such as Planned Parenthood, probation, and public health in the policy formation process. Another study participant noted that policies are usually developed to fix something that "has gone wrong"—a more reactionary response.

> *You know what, that is actually a question for management, per se. I know that they have their upper management meetings, they meet with the state, and they're presented with issues that are really important…things that they want to be implemented in dependency. Then it comes back to your home county, and it gets implemented through our analysts and our…training department…then down to us.* —Social worker

Study participants included multiple leaders and decision makers, several of whom had well defined roles in overseeing department procedures. The two participating deputy/assistant directors for Social Services shared their approaches to identifying issues of concern. One deputy director discussed the importance of leadership that encourages social workers to bring issues and problems to their attention, and a mechanism for policy change. In her opinion, such an "open door policy" by a deputy director was both necessary and likely rare across other, larger, counties. Key to her model for policy change is acting on the needs can concerns voiced by social workers.

> *We have a huge medical marijuana problem…someone came in here the other day and said, "I really need a policy and procedure on how to assess need do we need trainings?" The social workers are the ones that typically tell me. I also do anonymous surveys…I also have focus groups with staff every year…and I just listen. What are the issues? What do you think needs to be improved here? And that is how I get all of the information I need from them. If I didn't act on it, then I wouldn't be seen in their eyes as a good trusting leader. So when I get information, I actually have to do something…It is more than just listening.* —Deputy Director

A second deputy/assistant director formed ad-hoc working groups with volunteers from the workforce to discuss and update policies as needed. Participation ranges from office assistant up to managers, allowing for input from a variety of department stakeholders.

> *Hierarchal level is not of most importance. What's important is getting an over-arching perspective on every policy we're developing and looking at. So rather*

> *than just having the policy department complete a policy when the need comes, we involve the entire workforce, anyone who is willing to be part of these workgroups to flesh the policy out and see it operationalized*. — Assist. Director

Statewide assessment summation

The statewide assessment provides a snapshot of the current county practices related to foster youth sexual and reproductive health needs, rights, services, and education among a sample of California counties. This assessment demonstrates that while child health professionals are aware of multiple sources of information, support and services for foster youth few counties have formal policies and procedures outlining and mandating the resources that youth receive. Referrals to external services were the most commonly cited resource for providing youth with sexual and reproductive health information. While conversations with social workers were also widely cited as a resource for youth, several study participants noted that social workers in their counties address youth sexual and reproductive health on a case-by-case basis.

As in the Santa Clara County (SCC) case study, Kingdon's model of agenda setting was similarly used as a framework for examining policy practices across the sampled counties. Since only two counties had formal stand-alone policies (Santa Clara and Los Angeles), the focus of this analysis centered on how and if problems were recognized and the identification of possible policy solutions, given various political contexts. Across counties, there was widespread recognition that the issues associated with youth sexual and reproductive health were significant and problematic for youth and child welfare staff. Social workers were perceived to be uncomfortable and inadequately trained to address these issues with foster youth.

Participants from two counties citied strong collaborative partnerships with public health nurses that provided resources and support to both youth and social workers. It was believed that public health nurses, or other medical professionals, were better trained to discuss sensitive and technical topics. Additionally, there was the opinion that specialized units of social workers that worked primarily with adolescents, were similarly better equipped to address the sexual and reproductive health needs of youth. However, the presence of collaborations with public health nurses and specialized adolescent units were cited by few counties; leaving most counties to rely on optional and periodic involvement in ILP workshops, and infrequent and inconsistent discussions with social workers.

An interesting finding from the statewide assessment was the perceived need for child welfare administrators to prioritize and mandate that social workers address youths' sexual and reproductive health needs. Given competing mandates and numerous work force demands, some child welfare staff believed that it would be difficult to make this a priority without administrative mandates. Furthermore, most study participants believed that youth, social workers and foster parents/caregivers in their county would benefit from a formal policy. Nonetheless, policy formation only occurred in one of the sampled counties (Los Angeles). Kingdon's model suggests that the missing element in other counties was an unsuitable political context. Only two counties (including Los Angels) cited conditions or factors that indicated the presence of political support; involvement and influence from external advocacy organizations in raising awareness about youth sexual and reproductive health needs. The lack of large scale political support for this issue across most counties that it was a possible missing factor in the agenda setting process.

CHAPTER 7: Discussion

Agenda setting across counties

Agenda setting within policymaking is a complex and unpredictable process of defining problems and identifying policy solutions within a highly political policy environment *(Kingdon, 1984)*. Kingdon's adapted Garbage Can model provides a framework (problems, policy solutions, and politics) for examining policy practices and agenda setting across counties with and without formal sexual and reproductive health policies aimed at addressing the unique issues and needs foster youth. Kingdon's first policy stream involves the identification of salient and relevant policy problems. Findings from both the case study and the statewide assessment demonstrate considerable problem recognition among both local level actors (i.e. social workers) and central level decision makers (i.e. child welfare managers and administrators) with regard to the perceived impact of unplanned pregnancies, teen births, and sexually transmitted infections on the health and wellbeing, educational attainment, employment opportunities, and emotional health of foster youth. The central level actors tend to focus on the long term consequences of early pregnancy and childbearing, while the local level actors concentrate on the logistics of ensuring that foster youth receive necessary services and support. This variation in problem recognition suggests different approaches, from two stakeholder groups with distinct viewpoints on the issues facing foster youth, to formulating problem definition and influencing the agenda setting process.

While study participants provide compelling anecdotal evidence illustrating foster youth issues and challenges, none were aware of the scope and magnitude of issues within their county due to non-existent or insufficient tracking of sexual and reproductive health outcomes for these youth. Though recognition of the sexual and reproductive health needs of foster youth was largely echoed across the participating counties, only two counties had formal stand-alone policies (Santa Clara and Los Angeles) and few of the other counties noted systematic procedures to address youth needs in this area. With the exception of the counties with formalized policies, the extent to which most counties address this topic is limited to optional and periodic involvement in ILP workshops, and infrequent and inconsistent discussions with social workers.

A distinction between the two counties with policies and the majority of counties without policies was the presence of stakeholder identified policy solutions, i.e. Kingdon's second policy stream. A disconnect between the recognition of youth needs and social workers' perceived willingness, ability and capacity to respond given multiple organizational constraints was revealed in the statewide assessment. First, many study participants believed that medical professionals or individuals extensively trained in topics including sexuality education, reproductive health, and healthy relationships should discuss sensitive topics of this nature with foster youth. Though medical professionals such as public health nurses (PHNs) were largely perceived to be better qualified to provide technical information and specific counseling for youth and to offer as needed support for social workers, only a few counties cited critical partnerships with local public health departments and PHNs for the delivery of sexual and reproductive health information and services to youth.

Second, the study participants from the statewide assessment further cited a lack of training on topics related to adolescent sexual and reproductive health as a barrier to initiating and facilitating sensitive and technical discussions with youth. The study findings revealed that few

counties offer sexual and reproductive health trainings for social workers. Of the counties that did provide trainings for staff, most did not offer the trainings consistently nor were the trainings mandated. Even fewer counties provided trainings for foster parents and caregivers. Conversely, the two counties with policies mandated training for social workers and mentioned the importance of training for foster parents/caregivers and youth. Despite the perceived lack of capacity and ability to respond to these specific youth needs among participants from the statewide assessment, these challenges were less relevant for social workers from specialized units accustomed to focusing on the needs of adolescent populations on a regular basis. Social workers from these units were believed to be highly proficient and more comfortable addressing sensitive topics with foster youth. Study participants minimally discussed the applicability of this policy solution, and some participants mentioned organizational and resource barriers associated with these specialized units.

Finally, several study participants from the statewide assessment noted that ensuring youth safety was the primary priority for many social workers. While foster youth sexual and reproductive health is viewed as relevant and important to addressing youths' overall health and well-being, several participants noted that the absence of a specific mandate from upper management was an obstacle to addressing this issue. Without administrative directives and prioritization of this issue, competing priorities, numerous mandates, high workforce demands, and limited resources influenced social workers' willingness and ability to systematically address youths' sexual and reproductive health. Consequently, social workers were less likely to allocate limited time and resources to this issue in the absence of administrative mandates. Child welfare staff from Santa Clara County (SCC) echoed the obligation to, first and foremost, address youth safety, however, they cited the role of the judges in prioritizing this issue and pushing it to an agenda.

The problems of conflicting role definition, insufficient training, and lack of prioritization demonstrates opposing issue framing among social workers, and potential barriers to identifying achievable policy solutions across the sampled California counties. The lack of prioritization among some social workers is an indication of an underdeveloped or unsuccessful problem stream due to competing mandates and multiple constraints that inhibit social workers from addressing youth sexual and reproductive health needs in the absence of an administrative directive. Further more, without mandates from upper level management and decision makers, social workers are not likely to expend limited resources pushing this issue onto an agenda.

The third policy stream necessary for agenda setting as defined by Kingdon is the right political climate. Study participants from the statewide assessment did not explicitly cite any of the traditional factors (i.e. changes in political atmosphere, election results or local government administration) that would indicate the presence of a suitable political context. Nonetheless, study participants from two counties (one with a formal policy and one with systematic procedures) mentioned involvement from prominent advocacy organizations in defining this problem and advocating for improved services and support for youth in their respective counties. In the county where policy development occurred, multiple child advocacy stakeholder groups pushed the county to increase their focus on reproductive health for foster youth. The involvement by influential advocacy organizations indicated a possible political climate that acknowledged and supported of the needs and rights of foster youth. Further examination of the role of advocacy coalitions is needed to fully understand the political context in which these organizations operated.

The SCC case study indicated strong involvement from two publically elected juvenile court judges. The judges credited their courts' distinction as dependency and juvenile justice Model Courts with providing them with the resources and encouragement to implement innovative systems changes and reforms to improve court practices aimed at addressing the needs of children and families. The National Council of Juvenile and Family Court Judges (NCJFCJ) bestowed the model court distinction on the SCC courts. This distinction along with participation in a national training for juvenile court judges on the sexual and reproductive health of court involved youth, jointly conducted by The National Campaign to Prevent Teen and Unplanned Pregnancy and the NCJFCJ, highlighted national attention on this issue. NCJFCJ's involvement demonstrated the influence of a new policy venue that not only helped to frame the problem and solution in the context of the role of court, but also invested resources to support local judges interested in addressing this issue, and provided a political frame for supporting these issues among court involved youth. Membership in an influential national professional network and attendance at the training conference provided SCC judges with the evidence and validation to define this problem in the context of an environment that fostered innovative systems and policy changes. The judges returned from the conference inspired and empowered to address this policy issue in their county.

The role of policy entrepreneurs in agenda setting

Policy theorists emphasize the significant role of policy entrepreneurs in developing and articulating problems and policy solutions that are deemed plausible and compelling given current political conditions. They also use their skill and persistence to formulate the link between streams, negotiate with stakeholders for critical couplings of streams, and seize opportunities for agenda setting during open policy windows *(Baumgartner & Jones, 1991*, *2009; Kingdon, 1984)*.

A major finding to emerge from the SCC case study was the influential role that the juvenile court judges played in prioritizing the issue of youth sexual and reproductive health in SCC. Participants from the SCC case study cited the judges as the most influential stakeholders in the policy formation process. Without their involvement, some stakeholders believed that the policy would not have been developed as quickly, if it had developed at all. The judges were not only instrumental in raising awareness about the issue, but they also established an agenda around this topic and assembled a diverse task force of county stakeholders to collaboratively push the policy formation process forward. As previously noted, the judges cited involvement with the NCJFCJ and the National Campaign as highly influential in providing evidence, legitimacy and resources to this issue.

County child welfare staff that participated in the statewide assessment did not indicate similar involvement by juvenile court judges around this topic in their respective counties. This possibly stems from differing levels of judicial problem recognition, political prioritization, and capacity to tackle such issues. This raises the question of whether similar agenda setting can occur in the absence of judicial involvement. Though data and cases from the statewide assessment are limited there was an indication of the ability of other influential policy actors to function as policy entrepreneurs.

The first demonstration of this was the strong involvement and influence from local advocacy coalitions in raising awareness about the sexual and reproductive health needs of foster youth.

Advocacy coalitions in two counties were able to prompt a significant response from their county department of children and family services; in one case the development of a formal policy was achieved and in the other case curriculum review and development was instigated. Participants from the former case demonstrated how pressure from the influential advocacy group and local stakeholders was largely responsible for initiating policy formation. A second demonstration of involvement from other influential policy actors was the role of two child welfare directors in creating systems and environments that foster bottom-up innovations from social workers. In one case, the director willingly identified problems and sought novel solutions within an organizational context that supported systems and policy changes to better meet the needs of foster youth. While not all counties have juvenile court judges with the same level of commitment and capacity to address this issue as SCC, these cases demonstrate the possible role for other influential stakeholder groups or organizations to work to promote policy change around this issue. These examples also aptly demonstrate Kingdon's assertion that no single policy actor or group of participants has the ability to dominate the agenda setting process *(Kingdon, 1984)*.

Kingdon's model suggests the importance of each individual policy stream in establishing problem defining and agenda setting during the policy process. The SCC case study demonstrates the convergence of three independent policy streams and the role of the judges in coupling the streams together at an opportune time, resulting in the development of a sexual and reproductive health policy for foster youth. Findings from the statewide assessment indicate the similar presence of the problem recognition among participating stakeholders with respect to the long term consequences of early pregnancy and childbearing among foster youth. However there were variations across the sampled counties with respect to stakeholder perceived policy solutions, issue prioritization given competing mandates and resource constraints, the presence of an amenable political climate, and involvement from influential policy actors. These variations may have contributed to how the problems and feasible solutions were defined among stakeholders, and lack of necessary agenda setting across most counties.

Complexity of policy implementation

The implementation experiences of policy stakeholders in SCC suggest limitations to the top down approach and reveal a largely bottom-up implementation approach that was influenced by multiple contextual factors and constraints. While the judges and members of the Reproductive Health Task Force were effective in creating a formal Department of Family and Children's Services (DFCS) policy, the implementation process demonstrates necessary buy-in and resources from multiple local level actors that may not have the capacity to implement the policy as intended by the central level policymakers. Furthermore, the involvement and required approval from multiple clearance committees and the lack of implementation consistency resulting from multiple organizational constraints and uncertainties described by participating stakeholders demonstrates several elements emphasized in the bottom-up approach. Furthermore, the focus among stakeholders on the presence of implementation constraints rather than attainment of mandated policy goals and objectives, gives additional credence to both the bottom-up approach *(Hjern, 1982)* and the influence of contextual factors during implementation *(Pressman & Wildavsky, 1984)*. The implementation story inherent in this case study reveals the dynamic interaction between the policy and the context in which implementation occurs making it difficult to determine if the implementation process resulted in desired policy goals.

The SCC case study provides a unique example of how an influential, motivated, and skilled stakeholder group was able to collectively promote policy change. Unfortunately, due to limited resources and infrastructure necessary to evaluate policy implementation and monitor youth outcomes, there are no available data to indicate the policy impact in SCC. While lead child welfare staff are committed to evaluating policy implementation, developing and conducting a full scale evaluation has yet to be prioritized. As noted above, SCC is not alone in their efforts to adequately track and monitor sexual and reproductive health outcomes for foster youth. In the absence of outcome data demonstrating the effectiveness of the policy it is not possible to determine whether the presence of a policy, in and of itself, has a demonstrable impact on sexual and reproductive health of foster youth. Thus, individuals attempting to increase services and support for foster youth in counties without policies, should recognize the difficultly associated with policy formation and implementation. Currently there is no guarantee that a policy is sufficient to create appreciable differences in the information, services and support that youth receive. Furthermore, this analysis does not indicate whether or not passing a policy is an important first step to increasing services; other available approaches may exist that do not require policy change.

Implications for statewide policy formation

This research reveals that among the sample of California counties only two counties (Santa Clara and Los Angeles) had formal, stand-alone, policies addressing the sexual and reproductive health of foster youth. The vast majority of county stakeholders were unaware of past or current efforts to develop a formal county policy addressing these issues. Most participants believed that their county would benefit from a formal policy that clearly documented county policies and procedures for addressing foster youths' sexual and reproductive health needs, including clarification of the roles and responsibilities of social workers. Other studies have similarly concluded that child welfare staff would benefit from "the establishment of clear, consistent policies and protocol related to their role and practices to promote positive reproductive and sexual health" *(Svoboda et al., 2012)*. Though there was considerable support for policy formation, participants identified substantial barriers to policy formation and implementation in their respective counties.

The statewide assessment revealed that a significant number of child welfare staff believe that prioritization from upper management and key decision makers is necessary for initiating policy change. Participants from the vast majority of county stakeholders cited the need for formal department mandates dictating that these issues be covered. This top-down approach is reflective of an organization culture replete with federal, state, local, and professional mandates. As such, child welfare staff faced with competing priorities and demands are more accustomed to implementing policies and procedures resulting from administrative directives.

This raises the question of whether it is realistic to expect that social workers address the sexual and reproductive health of foster youth within the context of their current roles and responsibilities. Findings from this study suggest that adding this expectation to the regular purview of social worker duties will require that social workers receive additional resources, support and administrative directives to address this issue with foster youth. The importance and utility of trainings for social workers and caregivers is documented in other studies with child welfare staff *(Constantine et al., 2009; Love et al., 2005)*, and underscores the importance of

including explicit provisions for staff training in policies addressing the sexual and reproductive health needs of foster youth.

Collaborations with medical professionals such as public health nurses were cited by some counties as important to providing youth with appropriate sexual and reproductive health information, services and support. The scarcity of well-established collaborative models across most counties challenges the feasibility of such a policy solution. The data are limited in determining whether this scarcity results from a lack of county resources, or if such partnerships had simply not been developed. Additionally, heavy reliance on referrals to external providers discounts the importance of trusting relationships between caring adults and youth as a factor associated with gaining and acting on reproductive health information *(Constantine et al., 2009; Haight et al., 2009; Love et al., 2005; Svoboda et al., 2012)*. Public health nurses (PHNs) offer critical youth access to detailed sexual and reproductive health information and services, but they are not be able to provide youth with necessary long term connections and case management that social workers can.

Given statewide and county budget problems the applicability of model may not be feasible for some counties. Though there are significant opportunities for social workers to partner with PHNs to collaboratively address youth needs, it is important to ensure that at least one trusting adult with a longstanding relationship with the youth broadly oversees that discussions are happening with youth and that they are receiving necessary resources and services, even if they are provided by a myriad of external and community providers.

Finally, the lack of established monitoring systems through child welfare departments is a concern that has been documented as a key and necessary step to better understand the scope of unplanned pregnancy and its prevention among youth in foster care *(Svoboda et al., 2012)*. Insufficient tracking of sexual and reproductive health outcomes was widely cited as a barrier to understanding the scope and magnitude of foster youth needs. None of the stakeholders from the participating counties, both those with and without formal policies, were easily able to articulate the incidence of unplanned pregnancies, teen births, and sexually transmitted infections. Three primary obstacles were cited. The first obstacle was the lack of resources, infrastructure, and centralized systems for tracking foster youth sexual and reproductive health outcomes. Second, youths' right to privacy and confidentiality precluded social workers from documenting any such outcomes in case reports without explicitly gaining youth consent. Finally, since all youth have the right to access confidential sexual and reproductive health services such as birth control and screening for STIs (and abortion) without the consent of a parent or legal guardian, it is probable that youth receive services and support without involvement from social workers—making these outcomes impossible to track.

Prior studies have echoed deficiencies in documenting and reporting of the prevalence of pregnancy and/or parenting *(Constantine et al., 2009; Krebs & de Castro, 1995; Love et al., 2005)*, and collecting data on abortions and adoptions for youth young women and men in foster care. Additionally without a system for documenting outcomes across jurisdictions and states, it will be very difficult to calculate birth rates for youth in foster care. Without such tracking, it is impossible to fully understand the scope and magnitude of foster youth's sexual and reproductive health needs *(Svoboda et al., 2012)*, thus making it harder to generate necessary resources and mobilize wide-spread support for this issue. As noted above, the inability to track sexual and reproductive health outcome data makes it difficult to demonstrate the impact of policies, and provide a sound rational for supporting policy formation and implementation.

Limitations

A primarily limitation to this study is the lack of generalizability due to the study design and methods. While the study provides a comprehensive description of policy formation and implementation history and experiences in Santa Clara County, findings from this case study can only be used as a basis for examining similar factors associated with policy formation in other counties. Similarly, findings from the statewide assessment of the sample of California counties can similarly describe the barriers and facilitating factors to policy formation among the sampled counties. Purposeful sampling techniques were used to identify counties based on several demographic factors and county characteristics in an effort to increase internal validity. Since there were few variations between participating and non-participating counties (non-responders), some generalizations could be drawn for the non-participating counties with similar sampling characteristics.

The study findings are further limited by sampling methods used in both the case study and the statewide assessment. In both situations, individuals knowledgeable about the sexual and reproductive health of foster youth were initially targeted. In the case of the statewide assessment, most counties did not have a designated representative overseeing this topic. Thus, identification of an appropriate and willing study participant was often a lengthy process that resulted in being referred to three to four different individuals before a study participant was identified. As a result of this process, there are considerable variations in terms of the positions and titles of the study participants. While the range of perspectives was an overall strength of the study the distinct perspectives of some participants are limited by small sample sizes. This increases the potential for a biased representation of these perspectives. To account for this limitation efforts were made to objectively balance the perspectives of participants from each professional group, and note when findings were based on the viewpoints of select participants.

A further study limitation pertains to the data collection instrument and methods. Some of the questions examining social worker knowledge of and access to sexual and reproductive health resources were based on self-report. The study design and instrument did not allow for triangulation of findings. Future studies should incorporate more valid measures of these constructs. Additionally, the principal investigator, who was fully aware of the study questions and aims, conducted all of the participant interviews. This adds an inherent level of bias with respect to the interpretation of findings. Utilization of a semi-structured interview tool that was used across all study participants helped to limit extreme variation across participants. However, the nature of the qualitative methods lends itself to greater interpretation of results. Due to limited resources, the standard measures for strengthening internal validity, such as multiple coders and reliability checks were not incorporated into the study protocol.

Conclusion

The Santa Clara County (SCC) case study demonstrates the feasibility of policy change given the presence and alignment of necessary policy streams. The policy process in SCC suggests the importance of sufficient problem recognition, identification of feasible policy solutions, and an

amenable political environment. Two juvenile justice judges functioned as influential policy entrepreneurs, effectively bringing greater prioritization to this issue and promoting agenda setting. While the juvenile judges were key actors in the SCC policy process, there is evidence from the statewide assessment that actors from other policy venues can be influential in establishing problem definition and promoting agenda setting. However, this case study shows that formal policies cannot, by themselves, produce changes at the street level and that the implementation process is not easy and needs to be supported with ample resources and involvement of committed stakeholders. These findings are supported by the implementation literature that proposes that policy change is only a necessary first step in a longer process of creating new roles and practices.

However, the question remains as to whether or not policy formation is a sufficient solution given the lack of evidence demonstrating the success policy implementation and a substantive impact on youth outcomes. Though there is evidence from this study indicating that child welfare staff need a policy mandate to change current practices, additional evidence is needed to substantiate the content of these policies and the degree to which they should be implemented across various county settings. As such, it is necessary to develop comprehensive data tracking and monitoring systems that will provide a greater understanding of the scope of unplanned pregnancies, live births, parenting, adoptions, abortions, and sexually transmitted infections among young women and men in foster care. The availability of outcome data also has the potential to provide additional evidence and new problem framing around this issue that can be helpful to future policy entrepreneurs interested in promoting agenda setting and policy change. Additionally, without such established monitoring systems it will be difficult for county stakeholders to critically assess youth needs, and evaluate the impact of specific policies and procedures.

The development of systems that allow inter-agency data sharing among state and local child welfare agencies will facilitate the tracking and monitoring process *(Svoboda et al., 2012)*. Despite insufficiencies in current data collection procedures and systems, counties should still examine the relevance and feasibility of developing sexual and reproductive health policies to improve the information, services and support that youth receive. Nonetheless, given the numerous potential benefits associated with policy formation and implementation the lack of current outcomes data should not deter counties from developing policies and procedures that clarify how youths' sexual and reproductive health should be addressed. Instead, counties would be advised to allocate resources for evaluating policy implementation and monitoring outcomes, even if on a limited scale.

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APPENDICIES

APPENDIX I. Case study: Summary of participating agencies and organizations

Santa Clara County Department of Children and Family Services

The Santa Clara County Department of Family and Children's Services (DFCS) is a department within the Social Services Agency. DFCS works "to protect children from abuse and neglect, promote their healthy development and provide services to families which preserve and strengthen their ability to care for their children." From fielding concerns/compiling reports via the Child Abuse and Neglect Center (CANC) to utilizing differential response models to intervene, Emergency Response social workers attempt to keep children in the county safe. DFCS also ensures that vulnerable youth are placed in a proper home through adoption or foster care services, by offering voluntary relinquishment assistance to birth parents and by upholding the Safely Surrendered Baby Law.

With over 1500 children placed in supervised foster care per year in Santa Clara County, matching children with proper homes to meet their needs is crucial. Adoptive and foster parents are educated and licensed through DFCS, as well as assisted by social workers in connecting to community agencies and resources. Twenty-three public handbooks detailing policy and practices related to public child welfare services in Santa Clara County can be found online, so as to be accessible to both DFCS staff and the public.

Through Santa Clara County's California Connected by 25 (CC25) Initiative, the department not only targets mistreated children or those in need of adoptive and/or foster care services but also young adults that have "aged out" of the system. With the help of community partners, Santa Clara County focuses on services in housing, education and employment every year to the 150 young adults (ages 18-25) that emancipate from foster care, in hopes of preparing the youth for successful independent living by age 25.

Superior Court of California: Santa Clara County

Juvenile Division

The Superior Court of California: County of Santa Clara's court system is organized into various divisions, so as to best meet the legal needs of residents. The Juvenile Division manages cases related to minors that violate the law, or children that have been abused or neglected. Two subdivisions exist within this system: the Juvenile Justice Court and the Juvenile Dependency Court.

Juvenile Justice Court

The Juvenile Justice Court tries children below the age of 18 that commit a crime. The mission of this court is to "protect and rehabilitate our youth, build strong and healthy families, redress victims, and increase the safety of our community." The Court seeks to treat, handle and/or guide

minors that break the law, while being conscious of protecting the public and helping victims. Many community programs have been developed and implemented through the Juvenile Justice Court that target everyday youth, at-risk minors and victims through education and support. The Educational Rights Project: Youth Education Advocates Program, for example, makes special education accessible for children in the system. In addition to community-based programs, the Court manages released minor programs to ensure that the public remains safe and the youth offenders gain skills, remain in school and do not repeat their criminal activity once released.

Juvenile Dependency Court

The Juvenile Dependency Court tries cases regarding minors that are neglected and/or abused. With the underlying intent to protect and provide stability to children, the Court attempts to keep minors with their families when it can, and/or strengthen families and improve home conditions so that the child can then return. If the child cannot be returned to the home, it is the responsibility of the Court to make sure that someone takes custody of the child so that he/she is safe. Many services are offered through Juvenile Dependency to assist families with drug and substance abuse problems, mental health issues, proper parenting skills, and issues with domestic violence. Health and education services are also available.

Santa Clara County: Office of the County Council

The Office of the County Council in Santa Clara County is a team of attorneys that provides legal advice to the County Board of Supervisors and county officers to help them carry out policy goals. They help to negotiate and draft contracts and legal documents for various county entities. The legal council attorneys operate through several major practice areas including the following: Health and Hospital Services, Social Services Agency, and Child Dependency. For the child dependency area, they represent the Social Services Agency and the Department of Family and Children's Services (DFCS) in all juvenile dependency court proceedings, which includes youth in foster care.

Santa Clara County Probation Department

Santa Clara County Probation Department's mission "is to reduce crime and protect the community through prevention, investigation, and supervision services and safe custodial care for adults and juveniles." The Juvenile Division offers services through both the Detention Center and Rehabilitation Facilities to minors in the system. The Juvenile Detention Division manages the County juvenile detention facility (Juvenile Hall), community release programs and services/programs implemented in Juvenile Hall. In order to address the multidimensional needs of the youth, as well as to improve their social reintegration, programs such as career planning, Planned Parenthood and literacy are provided to young offenders. Juvenile Rehabilitation Facilities provide treatment and educational services to clients in low security residential ranches. The Community Based Aftercare program helps youth transition back to the community with services that address mental health, education, family/community support and substance abuse.

Santa Clara County Juvenile Hall Clinic

In Santa Clara County if a judge determines that a minor should be incarcerated, they go to one of the three local county facilities: Juvenile Hall, Muriel Wright Residential Center, or the William F. James Boys Ranch. After a juvenile's case is decided, he/she may be transferred to a state facility. Juvenile Hall has the capacity to provide temporary residential housing to 390 boys and girls. While at Juvenile Hall youth have access to a medical clinic, a mental health clinic, and religious services. The Wright Residential Center is a rehabilitation center for 64 minors and the Ranch is a 96-bed facility for boys aged 15½ to 18 years. All of these centers provide multiple services that strive to assist youth with their social reintegration back into the community at a later date. These services address social, physical, behavioral, psychological, emotional needs.

Planned Parenthood Mar Monte

Planned Parenthood Mar Monte (PPMM), the largest Planned Parenthood affiliate in the United States, reaches more than 250,000 individuals every year in 29 counties throughout mid-California and 13 counties in Northern Nevada through medical/educational services, and advocacy initiatives. The mission of this non-profit organization is "to ensure that every individual has the knowledge, opportunity, and freedom to make every child a wanted child and every family a healthy family." The 32 health center locations ensure that youth, parents and adults have access to resources related to sexual health and primary care regardless of their income through the help of state-funded programs, such as Family PACT and Medi-Cal. Teens are always welcome at health centers, and will never be turned away for failing to produce IDs or insurance cards.

APPENDIX II. Description of county characteristics

The following target characteristics were assessed for each sampled county to provide a more in depth description of each county.

- Total foster care population: In 2010 the foster care population ranged from 18,883 children (Los Angeles County) to zero children (Alpine County) at a single point in time *(Center for Social Services Research, 2010)* Due to the large range in population size, counties with less than 240 children were excluded from the study. These counties were deemed likely to have too small an adolescent population at any one time for meaningful comparisons to be made among counties with larger child populations and potentially greater resources.
- Teen pregnancy rates: At this time county-level teen birth rate data are not available for foster youth. However, data are available for all teens (15 to 19 years) living in a particular county *(Constantine et al., 2012)*. As such, these data were used as a proxy for overall sexual risk in the adolescent population. It should be noted that since rates of teen births are considerably higher among youth in foster care, these data are not an accurate estimate of sexual risk among the foster care population.
- Geographical location: California is divided into 11 regions *(The California Voter Foundation, 2012)*. To the extent possible, counties from as many of these regions as possible were included in the study. Eastern Sierra, North Coast, and Gold Country areas were not included in the sampling because these counties have foster care populations or teen pregnancy rates that do not meet the sampling criteria.
- Race and ethnicity: Sexual and reproductive health outcomes for foster youth vary by ethnicity. As such it is important to consider variations in the ethnicity of the foster care population across counties. 2010 data from the Child Welfare Gateway indicate that white (41%) and black (29%) children constitute the largest populations of children in care are any one point in time *(Child Welfare Information Gateway, 2012)*. To account for potential differences across counties, a range of counties with variations in the rate of white and black children in foster care were included.
- County level politics: In SCC, the topic of personal biases among social workers having conversations with youth about their sexual and reproductive health needs was extensively discussed during policy formation. While there is no direct county-level measure of personal biases with respect to sexual and reproductive health, data are available for voting in past presidential elections. For this study, county voting records were used as a proxy for the liberal and conservative nature of individual counties. Voting records from the last 10 voting cycles (1972 to 2008) were used *(Wikipedia)*. If the county voted democratically six or more times they were labeled “Dem.”; five times exactly were labeled “split”; and four or fewer times were labeled “Repub.” This was an arbitrary designation selected to approximate county level politics.
- California Connected by 25 (CC25) Initiative: The goal of this initiative is to use positive youth development and integrated systems of support and services to address the needs of transitioning foster youth. Currently eight California counties are participating in this initiative (Fresno, Humboldt, Orange, San Francisco, Santa Clara,

Stanislaus, Solano, and Glenn). Since the establishment of the CC25 Initiative in 2005, participating county child welfare agencies receive additional support and services for transitioning youth. A documented priority outcome is the "percent of youth who have given birth to, or fathered any children that were born" *(California Connected by 25 Initiative)*. Inclusion of this outcome suggests recognition of the potential impact that childbearing has on the lives of youth in foster care. As such counties participating in this initiative may have established greater problem definition and/or contemplated policy formation. Five of the sampled counties are participating in the CC25 Initiative.

- NOTE: Involvement of the courts was a key facilitating factor in policy formation in SCC. Unfortunately, there was no systematic way to categorize counties with more or less progressive county juvenile justice judges. While SCC holds the Model Court distinction, this is something afforded to only one county per state.

APPENDIX III. Sampled California county profiles

	County	State Region[a]	2010 Total State Population[b]	2010 Foster Care Population[c]	2010 Teen Births[d]	2010 Teen Birth Rate (per 1000)[d]	Race/Ethnicity of Children in Foster Care (% Hispanic/ Latino, %Black, %White)[e]	Presidential Voting: 1972-2008 (% Dem.)[g]	Political Designation (>50% = Dem.)[g]
	California		**37,253,956**	**57,651**	**43,127**	**29.0**	**47%:25%:25%**		
1	**Los Angeles**	Southland	9,818,605	18,883	11,677	27.3	**54%**, 33%, 11%	70%	Dem.
2	**Riverside**	Inland Empire	2,189,641	3,957	2,918	29.9	**53%**, 16%, 29%	20%	Repub.
3	**San Diego**	Southland	3,095,313	3,843	3,163	27.3	**47%**, 22%, 25%	20%	Repub.
4	**San Bernardino**	Inland Empire	2,035,210	3,535	3,476	37.1	**48%**, 23%, 27%	30%	Repub.
5	**Sacramento**	Sacramento Valley	1,418,788	3,274	1,594	28.7	23%, **40%**, 31%	60%	Dem.
6	**Orange**[f]	Southland	3,010,232	2,508	2,479	21.4	**61%**, 5%, 28%	0%	Repub.
7	**Fresno**[f]	San Joaquin Valley	930,450	2,348	2,023	49.9	**60%**, 15%, 19%	30%	Repub.
8	**Kern**	San Joaquin Valley	839,631	2,030	2,010	56.0	**50%**, 13%, 36%	0%	Repub.
9	**Alameda**	Bay Area	1,510,271	1,805	1,059	21.2	19%, **60%**, 17%	100%	Dem.
10	**San Francisco**[f]	Bay Area	805,235	1,353	229	18.1	24%, **59%**, 9%	100%	Dem.
11	**San Joaquin**	San Joaquin Valley	685,306	1,234	1,071	33.1	**42%**, 27%, 26%	30%	Repub.
12	**Santa Clara**[f]	Bay Area	1,781,642	1,146	1,176	19.5	**63%**, 13%, 18%	60%	Dem.
13	**Contra Costa**	Bay Area	1,049,025	962	743	19.5	22%, **43%**, 29%	60%	Dem.
14	**Tulare**	San Joaquin Valley	442,179	803	1,122	56.2	**66%**, 4%, 28%	0%	Repub.

15	**Merced**	San Joaquin Valley	255,793	703	509	43.1	**57%**, 12%, 25%	40%	Repub.
16	**Butte**	Sacramento Valley	220,000	655	205	22.6	16%, 7%, **69%**	20%	Repub.
17	**Ventura**	Southland	823,318	622	932	29.7	**60%**, 5%, 33%	30%	Repub.
18	**Stanislaus**[f]	San Joaquin Valley	514,453	609	807	33.2	35%, 14%, **49%**	40%	Repub.
19	**Santa Barbara**	Central Coast	423,895	552	638	38.3	**70%**, 5%, 24%	50%	Split
20	**Shasta**	Northern Mountains	177,223	534	196	28.4	18%, 4%, **70%**	20%	Repub.
21	**Sonoma**	Wine Country	483,878	503	355	20.7	32%, 7%, **54%**	60%	Dem.
22	**Solano**[f]	Bay Area	413,344	374	371	22.7	21%, **43%**, 29%	70%	Dem.
23	**San Luis Obispo**	Central Coast	269,637	321	198	19.6	31%, 5%, **62%**	20%	Repub.
24	**Monterey**	Central Coast	415,057	287	775	49.8	**72%**, 9%, 18%	50%	Split
25	**Kings**	San Joaquin Valley	152,982	267	298	48.2	**53%**, 19%, 26%	0%	Repub.
26	**Santa Cruz**	Central Coast	262,382	254	257	30	**48%**, 6%, 45%	80%	Dem.
27	**Imperial**	Inland Empire	174,528	244	417	52.9	**84%,** 4%, 8%	50%	Split

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APPENDIX VI. Policy Comparison

An examination of existing sexual and reproductive health policies was conducted to identify similarities and unique qualities across counties. Two counties, Los Angeles and Santa Clara, were found to have publically available sexual and reproductive health policies pertaining to foster youth. These policies were stand-alone policies that outlined department procedures, critical issues, guidelines, and stakeholder responsibilities (i.e. social workers, caregivers, and/or youth) with respect to issues of youth sexuality, reproductive health, pregnancy, and teen parenting. During the statewide assessment one additional county (Kings) indicated the presence of similar procedures. While this information was not publically available, this county was willing to share their policy information. It should be noted that the policy information was not in the form of a stand-alone policy, but rather policy elements contained in other existing policies.

Comparison of documented county sexual and reproductive health policies

	Los Angeles County	Santa Clara County	Kings County
Title	Procedural Guide 0600-507.10 "Youth Development: Reproductive Health"	Procedural Guide 15.3 "Reproductive Health"	Multiple documents
Link to Policy Online	http://file.lacounty.gov/dcfs/cms1_171808.pdf	http://www.sccgov.org/ssa/opp2/15_health/15-3.html	NA

Background Information	• Department role
	• Descriptions:
	  ○ Reproductive health
	  ○ Sexually transmitted infections (STIs)
	  ○ Unintended pregnancy
	  ○ Pregnancy and parenting
	• Statistics
	• Associated risk factors
	• Consequences of adolescent sexual risk taking
		• Descriptions:
		  ○ Comprehensive sexuality education
		  ○ Talking to youth about reproductive health
		  ○ STIs
		  ○ Sex education in public schools
		  ○ LGBTQ Issues
		  ○ Human Papillomavirus
		• Statistics
		• Consequences of adolescent risk taking	

Policy Objectives	1. Provide teens with information, skills and support to practice safe sex 2. Increase access to reproductive health care 3. Increase the role males play in preventing adolescent pregnancy 4. Prevent teen pregnancy and STIs 5. Support youth in managing an unintended pregnancy	1. Provide youth with information on human development, sexuality, and healthy relationships 2. Give youth tools to make responsible decisions 3. Provide access to reproductive health care services 4. Reduce unintended teen pregnancy and STIs	

Social Worker Responsibilities	• Discussions with youth • Discussions with caregivers • Referrals to Planned Parenthood and local county clinics • Support for pregnant and parenting youth	• Discussions with youth • Discussions with caregivers • Training in reproductive health • Ensure youth access to reproductive health services • Attend training on reproductive health • Support for pregnant and parenting youth	
Caregiver Responsibilities	•	• Attend training • Discuss personal biases and barriers with social worker	• Attend training
Youth Responsibilities	•	• Attending training on reproductive health • Utilize appropriate services • Follow medical guidelines • Notify social workers of barriers	
Public Health Nurses Responsibilities	• Consultations with social workers • Joint response or collaborative planning	• Consultation with youth • Referrals	
Discussion Guides	• Multiple topics included	• Multiple topics included	
Sexuality and Pregnancy/STI Prevention Topics *(Including but not limited to the following)*	• Age-appropriate education • Reinforce community norms • Implications of teen pregnancy • Pregnancy prevention options • STI Prevention standards • STI risks and treatment options	• Accurate information • Decision making skills • Reinforce community norms • Healthy relationships • Pregnancy prevention options • STI risk and treatment options • HPV vaccine benefits	*For caregivers:* • Adolescent issues • Sexually abused child • Human trafficking • Sexually abused child • Talking to children about sex • Building self-esteem *For youth:* • Comprehensive sex education • Parenting basis
Procedures for Pregnant & Parenting Teens	• Managing pregnancy • Voluntary relinquishment • Pregnancy termination • Adoption • Parenting youth • Safe pregnancy and promotion of child health	• Pregnancy options and issues • Voluntary relinquishment • Pregnancy termination • Adoption • Parenting youth • Safe pregnancy and promotion of child health	

Youth rights	• Right to privacy and confidentiality
	• Youth consent
		• Right to privacy and confidentiality
		• Youth consent
		• Documentation in:
		  ○ CWS/CMS
		  ○ Case plan
		  ○ Court report
			• Child's personal rights

Overviews of Legal Statutes	• Civil codes • Family codes • Health and safety codes • Penal codes • Legal precedence	• Children's legal rights • Public Health Service Act • California minor consent laws • Standing order on reproductive health • Standing order permitting health assessment	• Family codes • California minor consent laws
Other	• Resource contact information • Related county policies • Cross reporting with law enforcement	• Youth placed out-of-county	• Disclosure of dangerous propensities to foster parents

APPENDIX V. Statewide Assessment Interview Guide

California County Survey: Examination of policies and policy formation across the state

Survey Questions and Interview Prompts for Child Welfare Professionals

Demographic Information

County:		**Date:**	
Name:		**Gender:**	(a) Female (b) Male
Position (Title): *(Source UCAN)*	(a) Program director (b) Foster care case manager (c) Foster care supervisor (d) Other (please specify) ____________________	**Years in child welfare:** *(Source UCAN)*	(a) < 1 year (b) 1 – 3 years (c) 4 – 6 years (d) > 6 years
Total FC population	See Appendix III	**County teen birth rate**	See Appendix III
Ethnicity	See Appendix III	**County politics**	See Appendix III

Survey Questions

Policy and procedural measures

[Insert into Survey Monkey]

Current services

1. What kinds of services for preventing pregnancy and sexually transmitted diseases (STDs) does your County's Children and Family Services provide to foster youth aged 14-17? Please select all that apply. *(Source: Constantine N, adapted)*
   a. Counseling and discussions with case managers and social workers
   b. Referrals for resources and services
   c. Visits with public health nurses
   d. Training in adolescent sexuality or family planning for caseworkers
   e. Training in adolescent sexuality or family planning for foster parents/caregivers
   f. Training in adolescent sexuality or family planning for foster youth
   g. ILP resources (i.e. sexual and reproductive health education, services, and support)
   h. Program for pregnant or parenting youth
   i. Programs for young men
   j. Other (Please specify ____________)

2. If your county provides training in adolescent sexuality or family planning, for whom is the training mandated?

a. Caseworkers [Y/N/Not sure]
b. Foster parents/caregivers [Y/N/Not sure]
c. Foster youth [Y/N/Not sure]
d. Other (Please specify ____________)

3. Who has the main responsibility for discussing these services with foster youth? *(Source: Constantine N)*
    a. Foster parents and other caregivers,
    b. Caseworkers from your agency,
    c. Independent Living Programs
    d. Community based organizations,
    e. The public school system,
    f. Other (Please specify ____________)

4. (**Youth access**) From your perspective, how aware are child welfare staff regarding the content and sources of sexual and reproductive health information and services available to foster youth?
    a. Completely aware
    b. Partially aware
    c. Completely unaware
    d. Not sure

<u>**County Policies and Procedures**</u>

5. Does your county currently have documented sexual and reproductive health policies or procedures for foster youth (i.e. trainings, discussions with youth, confidentiality, etc.)? *This includes procedural language that may be present in other policies related to foster youth health and wellbeing.*
    a. Yes
    b. No [If no, go to Q9]
    c. Not sure

6. How clear are the policies or procedures outlined for caseworkers?
    a. Extremely clear
    b. Very clear
    c. Mostly clear
    d. Somewhat unclear
    e. Totally unclear
    f. Not sure

7. Do the policies or procedures include minor confidentiality and consent laws?
    a. Yes
    b. No
    c. Not sure

8. Are caseworkers routinely asked to provide information regarding youth sexual and reproductive health in court reports?
    a. Yes
    b. No
    c. Not sure

9. Does your county currently collect sexual and reproductive health outcome data for foster youth (i.e. pregnancies, births, STDs, etc.)?
    a. Yes
    b. No
    c. Not sure

IRB Disclosures

Affiliation: UCB doctoral student in the School of Public Health

Purpose: The focus of this study is the sexual and reproductive health of foster youth in California. I am specifically examining sexual and reproductive health policies and procedures across the state, with a particular interest in issues related to policy formation. The content of the survey and interview questions are not particularly sensitive, as I am primarily interested in the various access points for youth to receive services/education, and opportunities and barriers to policy formation with respect to sexual and reproductive health.

Confidentiality: The survey and interview will be confidential and no counties or individuals will be linked to any responses. I plan to write up the findings for my dissertation and then disseminate a policy brief to the participating counties. I would like to more broadly disseminate the findings if warranted.

Permission to audio record: With your permission, I would like to audio record the interview for transcription purposes only. The audio file will be deleted at the completion of the study. (Y / N)

Interview Prompts

Policy formation and implementation measures

1. (**Problem definition**) How is the issue of teen pregnancy, childbearing, and/or sexually transmitted diseases a problem among foster youth in your county?

2. (**Unmet need**) To what extent do you believe that the sexual and reproductive health needs of foster youth are being met in your county?

3. **(Prioritization)** How is this issue prioritized among other issues and services for foster youth?
    a. How long has this topic been prioritized?
    b. If this topic was newly prioritized, what was the reason?

4. (**Barriers**) What are the most difficult barriers to more effectively helping foster youth prevent pregnancy and STDs? *(Source: Constantine N)*
    a. (**Difficult topic**) How comfortable are caseworkers in discussing this issues with foster youth?
    b. (**Personal biases**) From your perspective, how influential are personal biases during discussions with youth on this topic?

5. (**Stakeholders/Champions**) Are there currently any agencies, community based organizations (CBOs), and/or individuals in your county that are involved in addressing this topic among foster youth?
    a. If so which organizations are involved?
    b. (**Culture of collaboration**) What collaborative efforts are currently or have in the past taking place?
        - **(Advocacy coalition)** Have any influential coalitions of stakeholders formed as a result of the collaboration?
        - (**Key stakeholder**) Who has been primarily responsible for leading the collaborative efforts?
        - (**Agenda setting**) Who has been responsible for establishing the agenda?
    c. (**Court involvement**) How involved are dependency and juvenile court judges in this issue?

6. (**Policy Benefit**) From your perspective, would your county benefit from a sexual and reproductive health policy for foster youth? Why or why not?

7. (**Policy formation**) Has your county attempted to develop a policy to explicitly address the sexual and reproductive health of foster youth?
    a. If so, why or why not?
    b. **(Primary policy barrier)** Based on your perception, what is the key factor preventing policy formation in your county?
    c. (**Key facilitating factor**) If your county was to develop a policy regarding this topic, from your perspective, what would be the single most important agency, individual, or reason why this policy could be developed in your county?

8. (**Additional issues**) Are there any other issues related to youth sexual and reproductive health that I have not already asked about?

Thank you

National Campaign: Would you like to receive information about the issue of teen pregnancy among foster youth? [*If yes, send PDF reports and links*].

Compensation: $15 gift card to Peet's or Starbucks (Y / N)