Center for the Study of Social Policy

EXPECTANT & PARENTING YOUTH IN FOSTER CARE

ADDRESSING THEIR DEVELOPMENTAL NEEDS TO PROMOTE HEALTHY PARENT AND CHILD OUTCOMES

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DOMAIN I:
Physical, Sexual and Reproductive Health and Development

Developmental Need 1: Having an approachable, knowledgeable, non-judgmental adult with whom one can freely discuss physical, sexual, and reproductive health issues

Expectant and parenting youth need adults in their lives who are willing and prepared to have open, honest, non-judgmental, two-way discussions with them about issues related to sexual intercourse, sexual decision-making, contraception, protection from STIs, pregnancy, sexual assault and exploitation and any other topics related to physical, sexual and reproductive health (Boonstra, 2011; Harrison, 2015, The National Campaign, n.d.). Expectant and parenting youth also need to be able to talk with a trusting, non-judgmental adult about their feelings regarding being pregnant or becoming a mother or father. Parents, family members in a parental role, foster parents, social workers and others who work with youth can benefit from training about creating a comfortable environment for and regularly engaging both young men and women in these type of discussions. The need for foster parents to be approachable and prepared to discuss sensitive sexual issues with youth in care, was indicated in findings from a 2005 qualitative study conducted by The National Campaign.

> *It is clear that youth want to have more conversations about sex with their foster parents and feel they can learn from them. Many of the teens report that they are not currently having these conversations either because they are embarrassed or because their foster parents never broach the subject. They feel they need to trust their foster parents before they talk to them. Some teens suggest that foster parents should be available for them when they are ready to talk and should listen to their kids. Youth feel it is important to start the conversation early and to be non-judgmental and supportive. One teen mother stresses the importance of open conversations: "Talk to the foster teens—really talk, in conversation. No "don't do this or that."*
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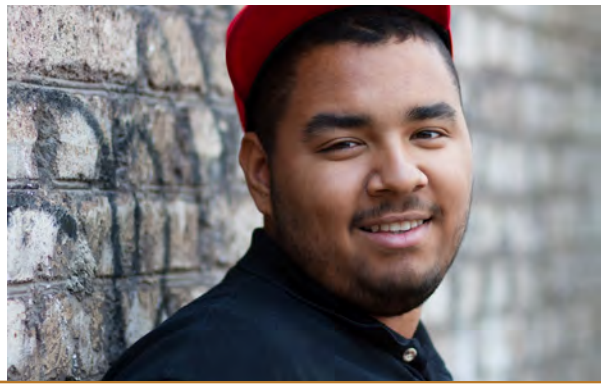
> (Love, et al., 2005, p. 15)

Circumstances related to youth being in foster care may be a barrier to having discussions about sexual issues with their foster parent(s). For example:

- When youth experience disruptions in placements they are less likely to forge strong relationships with their foster parent(s). "Disruptions also have ripple effects that may subsequently weaken teens' relationships with other key adult figures in their lives, thereby reducing the likelihood that teens will receive guidance on sexual and reproductive health concerns" (Manlove, et al., 2011, p. 7).
- Youth who have been placed in foster care as a result of being sexually abused, or who may have been sexually abused while in a foster care setting, may find having conversations about sexual issues with a foster parent to be extremely difficult. "For such teens, having conversations about dating and sexual relationships may be best handled under the guidance of professionals, such as counselors or therapists, because having to dwell on these topics may be emotionally charged and delicate" (Manlove, et al., 2011).

Expectant youth need convenient, accessible, timely and accurate information about reproductive and sexual health. This information is available via formal sources, including participation in sex education classes in school, clinics, social service programs and other group





Developmental Need 2: Having access to and timely receipt of accurate medical, contraceptive and reproductive health care and information

settings. Informally, youth may receive information and misinformation from family members, peers, the internet and other media. Although youth in foster care have access to and receive reproductive health care and information from formal sources at higher rates than adolescents not in care (Bilaver & Courtney, 2006), several challenges regarding access to information in these settings still exist (see Boonstra, 2011; Love, et al., 2005; The National Campaign, n.d.). Specifically:

1. Information is offered too late (after they are sexually active).
2. Only selected information is shared (for example, limited information about birth control or pregnancy options), so more information is necessary to help them make better choices.
3. Youth may feel embarrassed or intimidated about asking for contraceptives because they believe they will be judged.
4. Youth may distrust the effectiveness of contraceptives (for example, "I got pregnant even though I was on the pill.") due to having inaccurate or incomplete information.
5. The manner in which information is presented does not resonate with them. "Similar to youth in general, in order for messages in a sex education class to resonate with them, youth in care want to hear information delivered in a way that will connect with their personal experiences" (The National Campaign, n.d., p. 9).
6. Youth who experience inconsistent school attendance due to disruptions in placement may miss access to quality school-based sex education classes (Boonstra, 2011).

Expectant youth also need convenient, accessible, timely and appropriate prenatal and postnatal health care services and information that will enable them to progress safely through pregnancy, childbirth and early parenthood. Prenatal care helps to decrease or mitigate risks during pregnancy (for example, pregnancy-induced hypertension) and increase the probability of a safe and healthy delivery for both the mother and child. Through prenatal care, the physician can monitor the growth of the fetus and identify and respond to problems and complications. Postnatal care centers on providing relevant, timely information to new mothers to enable them to promote their own and their infant's health and well-being, as well as to recognize and respond to the signs and symptoms of problems. It also includes screening for and addressing changes in the new mother's typical mood, emotional state, behavior and coping strategies (National Institute for Health and Care Excellence, 2014).

Unfortunately, expectant youth are less likely than older expectant women to appreciate the importance of and receive prenatal care during their first trimester. Manlove and colleagues (2011) reported that "although teens in foster care have health coverage through Medicaid, a study of children in foster care in Illinois indicated that one in five teen mothers in foster care either did not receive any prenatal care or did not begin care until the third trimester" (p. 5). As a result, there is an increased likelihood of premature delivery, low birthweight, infant health and developmental problems and infant mortality (Kaye, 2012; National Association of County and City Health Officials, 2009; Schuyler Center for Analysis and Advocacy, 2008; SmithBattle & Leonard, 2012). Adolescent mothers and

fathers also need to receive comprehensive sexual and reproductive health counseling about the importance of delaying subsequent pregnancies and inseminations, contraceptive options, which contraceptive method would be best for them, how to use the chosen method(s) correctly and consistently and preventing sexually transmitted infections (CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, 2014b; Healthy Teen Network, n.d.).

An often overlooked counseling topic with expectant and parenting youth is sexual violence. Some early studies on rape-related pregnancy (see Boyer & Fine, 1992; Gershenson, et al., 1989; Holmes, Resnick, Kilpatrick, & Best, 1996) found that, among documented cases, the majority occurred among adolescents and resulted from a known, often related perpetrator. Manlove and colleagues (2011) reported that "one half (49%) of females who were ever in foster care during their youth experienced forced sex (either before, during, or after their time in foster care), a percentage that is more than four times that for females nationwide (11%)" (p. 4). Thus, counseling with expectant and parenting youth should also include discussions about incest; types of sexual violence, including commercial sexual exploitation[1]; the legal consequences of perpetrating sexual violence; the right to say no; and proactively responding to sexual violence if victimized.

Developmental Need 3: Engaging in healthy behaviors, in particular eating nutritious food and avoiding drug use

Engaging in unhealthy behaviors during pregnancy can cause damage to the developing fetus and result in poor child outcomes such as low birthweight, infant mortality and fetal alcohol spectrum disorders. Thus, expectant youth need to understand that having a healthy pregnancy is one of the best ways to promote the health of their developing child; that what they put in their bodies can directly effect their child's development. Studies have shown that expectant youth are less likely to eat healthy food, take recommended daily prenatal vitamins and gain adequate weight than older expectant women. Also, they are more likely to smoke cigarettes, drink alcohol or take drugs (Kaye, 2012; National Association of County and City Health Officials, 2009; SmithBattle & Leonard, 2012).

For example, a recent study using a large, nationally representative sample found that nearly twice the number of pregnant adolescents than non-pregnant adolescents (59 percent and 35 percent respectively) reported use of psychotropic drugs (i.e., drugs that alter perception, mood, thinking or consciousness) in the previous 12 months. The most commonly used psychotropic drugs were alcohol and marijuana and the use of substances decreased as the pregnant youth progressed from first into the second and third trimesters. (Salas-Wright, Vaughn, Ugalde, & Todic, 2015). Furthermore, "while the use of psychotropic medications has increased for the entire population, youth in foster care have demonstrably higher rates of psychotropic medication use than their peers who are not in foster care" (CSSP, 2013b, p. 1). Thus, concerns about the use of psychotropic drugs among pregnant adolescents are exacerbated when they are in foster care.

Developmental Need 4: Being sexually responsible to delay subsequent pregnancies and prevent sexually transmitted infections

An important message that expectant and parenting youth need to internalize is that both males and females need to be sexually responsible to delay subsequent pregnancies and STIs[2]. Adolescent pregnancy data show that almost 20 percent of births to youth ages 15-19 is a "repeat birth"—the second (or greater) pregnancy resulting in a live birth before age 20—and that 19 percent of second births occur within one year after the first delivery and 38 percent within two years of the first birth (CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, 2013a; Pinzon & Jones, 2012). Data from the Midwest Evaluation indicated that the prevalence

1 Commercial sexual exploitation "refers to the sexual exploitation of children (e.g., prostitution, sex trafficking, child pornography)... for financial or economic gain and, in every case, involves maximum benefits to the exploiter and an abrogation of the basic rights, dignity, autonomy, and physical and mental well-being of the child involved" (Harper, 2013, p. 1).

2 Recently, the phrase "sexually transmitted infection" (STI) is used more often than "sexually transmitted disease" (STD) because individuals may be infected but the infection may not show symptoms of or evolve into a disease.

of repeat births increases for young mothers in foster care. "By age 19, 46% of teen girls in foster care who have been pregnant have had a subsequent pregnancy, compared to 29% of their peers outside the system" (Bilaver & Courtney, 2006, p. 1).

Factors associated with increasing the likelihood of repeat pregnancies include not returning to school within six months after first delivery, intimate partner violence, lack or inconsistent use of contraception, having peers who are parents and postpartum depression (Pinzon & Jones, 2012). These factors highlight the need for interventions targeting expectant and parenting youth that focus on postnatal sexual and reproductive health counseling for adolescent mothers and fathers, supporting the return to and completion of school and screening for depressive symptoms.

The Guttmacher Institute (2014) found that youth and young adults ages 15-24 account for nearly half (9.1 million) of the 18.9 million new cases of STIs each year. Manlove and colleagues (2011) reported that, "compared with girls nationwide, girls in foster care were three times as likely to report having had a sexual partner with an STD. . . . In addition, young adult women who were ever in foster care were more than 50% more likely to test positive for an STD. . . than were young women who were never in foster care" (p. 4).Adolescent pregnancy and STIs are a potentially dangerous combination. Expectant adolescents should make sure they are screened for STIs at the initial prenatal visit and throughout their pregnancy if they remain sexually active.

> *The results of an STD can be more serious, even life-threatening, for a woman and her baby if the woman becomes infected while pregnant. It is important that women be aware of the harmful effects of STDs and how to protect themselves and their children against infection. Sexual partners of infected women should also be tested and treated.*
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> (CDC, Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014, para. 1).

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MANLOVE, WELTI, MCCOY-ROTH, BERGER, & MALM (2011)