

# Continuum of Care Reform: Improving Permanency Outcomes and Repairing Out of Home Care

## 2018 Regional Trainings

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MATERIALS



JUDICIAL COUNCIL  
OF CALIFORNIA

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OPERATIONS AND PROGRAMS DIVISION  
CENTER FOR FAMILIES, CHILDREN & THE COURTS

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PUTTING PARENTING FIRST

# Purpose of Convening

- Increase understanding of the Quality Parenting Initiative as a child welfare system change effort
- Enhance participants' ability to apply child development and brain science research to policy and practice in implementing CCR
- Identify strengths and barriers in local practice to ensuring excellent parenting for children and youth and implementing CCR
- Develop plans with judicial and agency leadership/staff and other key stakeholders to address barriers

The Youth Law Center advocates to transform foster care and juvenile justice systems across the country so every child and youth can thrive



## What is QPI?

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QPI is a strategy of the Youth Law Center. It is an approach to strengthening foster care, by refocusing on excellent parenting for all children in the child welfare system.





# Why.



To ensure **EXCELLENT, DEVELOPMENTALLY INFORMED PARENTING** for **EVERY child EVERY day**









# CCR

## Context for Today's QPI Discussion: California Continuum of Care Reform

- What Was the Need?
- The Policy Framework
  - Senate Bill 1013 (Chapter 35, Statutes of 2012) required legislative recommendations
  - Assembly Bill 403 (Chapter 77, Statutes of 2015) enacted major components of CCR



# CCR Vision

## CCR Vision

*“Every child and youth needs and deserves to feel love, a sense of attachment and belonging, and to have the continuity of family and community to support and guide them in their lives. Preserving or reunifying the family is the first priority, when possible, for all children and youth. When reunification is not possible, securing a permanent family through adoption or guardianship is the next-preferred priority. The overarching goal, reflected in this report, is to reduce reliance on group homes as a long-term placement setting by narrowly defining the purpose of group care, and by increasing the capacity of home-based family care to better address the individual needs of all children, youth and caregivers.”*



# CCR Vision

- Children live in their communities in homes where they receive quality parenting
- Services/supports individualized and coordinated across systems so children can receive support where they live
- Congregate care drastically limited to a short-term, high quality, intensive intervention designed to meet specific needs and quickly return youth to a family
- Effective accountability and transparency drives continuous quality improvement for state, county and providers



# CCR Strategies



- Limiting use of Congregate Care
- Improving Quality & Changing Goal of Group Homes → STRTPs
- Strengthening Collaboration
- Increasing Capacity for Family Care
- Core Services
- Increased Engagement

# QPI Principles

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Excellent parenting is the most important service we can provide to children and youth in care. Children need families, not beds;

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Child development and trauma research indicates that children need constant, consistent, effective parenting to grow and reach their full potential;

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Each community must define excellent parenting for itself

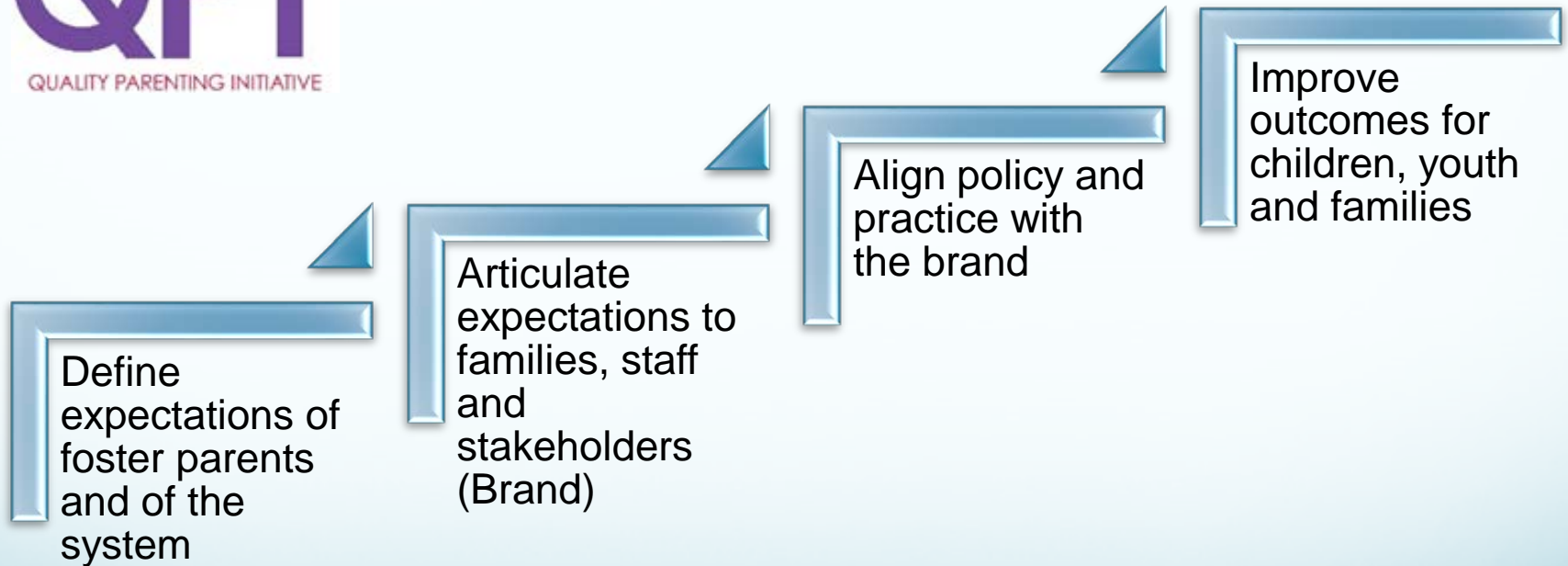
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Policy and practice must be changed to align with that definition

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Participants in the system are in the best position to recommend and implement that change;

# parenting for all children in the child welfare system.





# What.



- **MORE** families who are willing and able to be excellent parents to children in our system



# THE BRAND

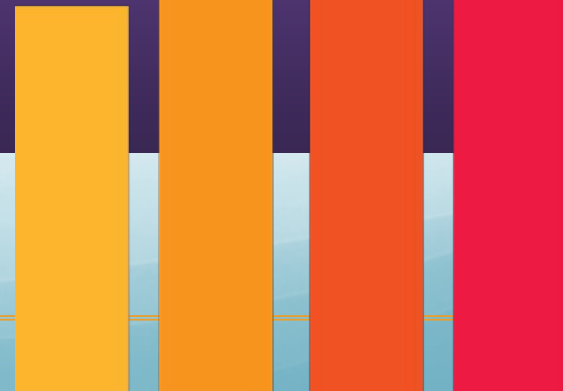
# How



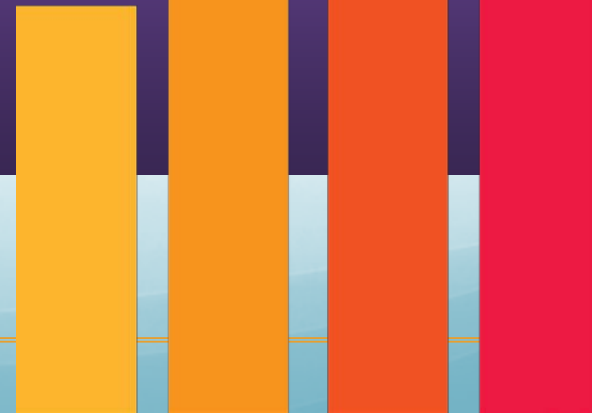
- **COMMITMENT** by the child welfare system to fully support excellent parenting by putting the needs of the child first

# How?

- SET clear expectations
- COMMUNICATE the expectations
- ALIGN system around those expectations



- **APPLY** research to practice
  - Developmentally informed care
  - Presentations on key topics
  - **Innovations**
    - Just in Time



# How.

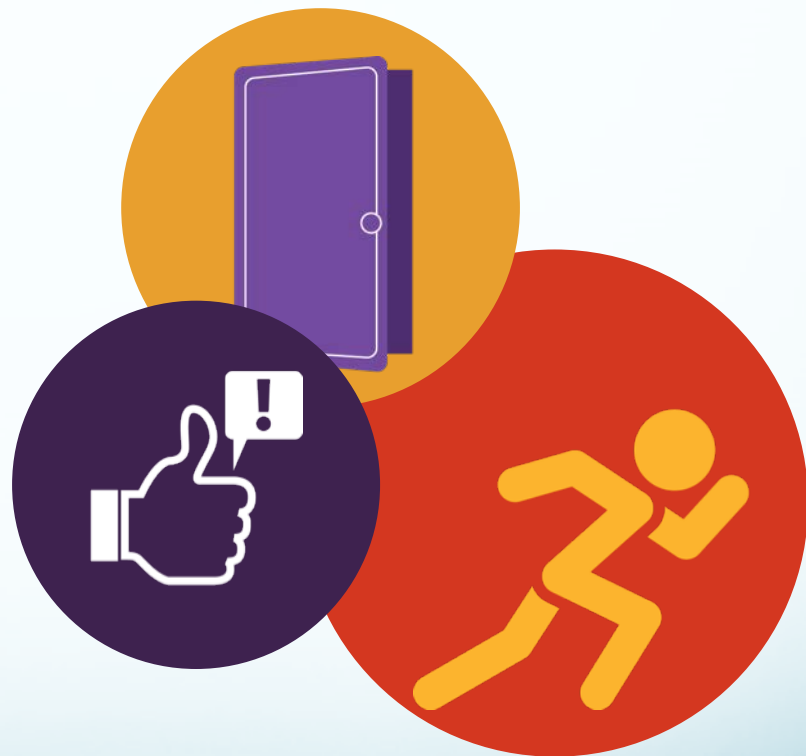


- **RECOGNIZE** that caregivers and social workers are professional partners
- **LISTEN** to those who do the work
- **RESPOND**



# Key Issues

- Information sharing
- Transitions
- Normalcy/Prudent Parenting
- Increased Involvement in Decision Making
- Recruitment, licensing, retention and support for quality
- High quality, quickly available, individualized training
- Co-parenting support
- Court





**results.**

- More quality families
- More effective birth teams
- Better decision making
- Changed policies
- Higher skill levels
- Better team work
- Long term relationships for children

**Improved Parenting for Children**



**Thank You!**

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# County of San Diego Partnership Agreement

Children need normal childhoods as well as loving and skillful parenting that honor their loyalty to their biological family and their need to develop and maintain permanent lifelong connections.



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## RESOURCE PARENT EXPECTATIONS

### Caregivers and Agency Staff Work Together as Respected Partners

- Caregivers will conduct themselves in a professional manner and will work together with Agency staff as a respected partner.
- Caregivers will share all relevant information and will provide input for the child's case plan.
- Caregivers will respect the privacy & confidentiality of all information related to the child & family.
- Caregivers will participate in all team meetings and court hearings.
- Caregivers will obtain and maintain records that are important and relevant to the child's well-being.

### Nurturing Children and Youth

- Caregivers will provide excellent parenting by being trauma informed.
- Caregivers must be willing and able to learn about child's culture & ethnicity to support the child's connections.
- Caregivers will fully incorporate the child into their family activities, including vacations.
- Caregiver will not give notice to remove child unless the removal is demonstrated to be in the best interest of the child or poses a safety risk to the child, caregivers or others in the home.
- Caregiver will participate and adhere to the child's transition plan developed by team members.
- Caregivers are expected to take advantage of all trainings they need to improve their skills as excellent parents.

### Supporting Families

- Caregivers will facilitate continuity for the child, with biological family by encouraging participation in medical related care, school, and other important activities.
- Caregivers will facilitate a smooth transition to another placement by sharing information about the needs of the child.
- Caregivers will respect and support the child's ties to family (parents, siblings, extended family members), and other significant relationships, and will assist the child in maintaining these relationships through facilitating appropriate visitation and other forms of communication in accordance with the case plan.

### Strengthening Communities

- Caregivers will advocate for children with the Agency, the court, and community agencies.
- Caregivers will support the child's school success; including: participating in IEP meetings, attending school events, school conferences assisting with school assignments and advocate/support tutoring.
- Caregivers will provide developmentally appropriate opportunities to allow children and youth to learn and practice life skills and have hands-on experiences in preparation for transition to adulthood.

X \_\_\_\_\_  
ACCEPTANCE OF AGREEMENT, *Caregiver*

Date \_\_\_\_\_



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# County of San Diego Partnership Agreement

Children need normal childhoods as well as loving and skillful parenting that honor their loyalty to their biological family and their need to develop and maintain permanent lifelong connections.



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## AGENCY STAFF EXPECTATIONS

### Caregivers and Agency Staff Work Together as Respected Partners

- Agency staff will conduct themselves in a professional manner and will work together with caregivers as a respected partner.
- Agency staff will share all relevant information regarding the child and family within the County established guidelines.
- Agency staff will support and facilitate caregiver participation in all team meetings and court hearings.
- Agency staff will provide timely notification to the caregiver for team meetings and court hearings.
- Agency staff will provide an alternative way for caregivers to participate in all team meetings if the caregiver cannot be present.

### Nurturing Children and Youth

- Agency staff will provide caregivers with the services and support they need to be excellent parents.
- Agency staff will support caregivers in overcoming barriers to full participation in family life and activities
- Agency staff will participate and adhere to the child's transition plan developed by team members.
- Agency staff is expected to remain current on trauma informed practice.
- Agency staff will support the child's connections to culture & ethnicity.

### Supporting Families

- Agency staff will support caregivers by working together as a team by communicating the family's reunification plan.
- Agency staff will support a smooth transition plan for the child by sharing information about him/her, and support contact between the child and initial foster family.
- Agency staff will provide caregivers with information, guidance and support necessary to fulfill their responsibility.

### Strengthening Communities

- Agency staff will support the caregiver's role as an advocate and respect their input.
- Agency staff will share with caregiver's information about the child's health and well being.
- Agency staff will support and facilitate the caregivers participation with all of the child's educational needs.
- Agency staff will support caregiver's decisions that meet the prudent parent standards.
- Agency staff will work with caregivers in facilitating appropriate opportunities to allow children and youth to learn and practice life skills and have hands-on experiences in preparation for transition to adulthood.

X \_\_\_\_\_  
ACCEPTANCE OF AGREEMENT, *Agency Staff*

Date: \_\_\_\_\_

**Congregate Care Chart**  
**Considerations for Judges after CCR**

<p style="text-align: center;"><b>Questions to ask when STRTP is Recommended</b></p>	<p style="text-align: center;"><b>Laws (Federal Laws, State Laws, State Directives)</b></p>
<p>What is the reason for the congregate care recommendation?</p>	<p>Placement must be in least restrictive, most family like setting. Case plan needs to discuss the safety and appropriateness of placement and must include the reason for that placement decision. Case plan must indicate the needs of the child that necessitate the placement, and the plan and projected timeline for transitioning the child to a less restrictive environment. <sup>i</sup></p>
<p>Are all criteria required under law and regulation met to justify the recommendation?</p>	<p>Treatment based rationale for congregate care is valid and supported by a comprehensive evaluation. Child understands the reason for placement. It is the least restrictive, most family like setting; visitation can occur to facilitate reunification; facility can meet the specific needs of the child; child can maintain his or her current school; child’s health and emotional factors are addressed; special needs of the child have been addressed. <sup>ii</sup></p>
<p>What are the specific needs of the child that require congregate care?</p>	<p>If congregate care is appropriate for the child, it must be because the child has specific and specialized needs that can only be met in group care. Funding is only available if the worker has documented that the placement is necessary to meet the treatment needs of the child and that facility offers those treatment services. The case plan must identify specific goals and the appropriateness of the planned services in meeting those goals. If the child is placed a substantial distance from the home of a parent or out-of-state, the case plan must specify why such placement is the most appropriate placement selection and whether that placement is in the best interest of the child. <sup>iii</sup></p>
<p>Can the identified treatment or special needs be met in a family setting? Why or Why not?</p>	<p>A group care placement can only be used once <i>all</i> efforts have been exhausted to provide services in a community/family-based setting. Each child must have a case plan designed to achieve placement in a safe setting that is least restrictive and most appropriate. <sup>iv</sup></p>
<p>Has a less restrictive environment been recommended or attempted?</p>	<p>The agency must consider the recommendations of the Child and Family Team (CFT), including if out of home placement is used to attain case plan goals. A child must be given a meaningful opportunity to participate in the development of the case plan and state his or her preference for foster care placement. If the child is 12 years of age or older and in a permanent placement, the child must be given the opportunity to review, sign, and receive a copy of the case plan. <sup>v</sup></p>
<p>Is the facility able to meet any identified special or noteworthy needs of the child (ex. sexual orientation, language, disability)?</p>	<p>Title VI requires nondiscrimination under programs receiving federal assistance through the Department of Health and Human Services. The Americans with Disabilities Act and Rehab Acts prohibit discrimination based on disability and require accommodations so that services can be provided in the most integrative setting. Out of home placement must be in the environment best suited to meet the child’s special needs and interests. All foster youth have the right to fair and equal access to services and to not be subjected to discrimination or harassment <sup>vi</sup></p>

Does the proposed congregate care facility have the capacity to meet the specific treatment needs of the child, including all necessary licenses and certifications?	Funding for congregate care is only available if the agency has documented that the placement is necessary to meet the needs of the child and that the facility offers those treatment services. <sup>vii</sup>
Will the child's educational needs be met in accordance with the law in a congregate care setting?	The case plan must include a plan for ensuring the educational stability of the child while in foster care, including that each placement of the child in foster care takes into account the appropriateness of the current education setting and proximity to the school in which the child is enrolled at the time of placement. <sup>viii</sup>
How will the child's needs for routine and preventive health care be met, including any special medical needs the child may have?	The case plan must ensure that the child receives medical and dental care which places attention on preventive care services through the Child Health and Disability Prevention (CHDP) program or equivalent. Each child must receive a medical and a dental exam within 30 days of placement. <sup>ix</sup>
How often and through what process will the need for congregate care placement be reviewed?	Congregate care stays should be of short duration and are required to have an exit strategy. Placement must be reviewed every six months. A CFT must be held every six months; if a child is receiving extensive mental health services, a CFT must be held every 90 days. <sup>x</sup>
What is the plan for including the child's family, caregiver and other important individuals in the child's treatment and visitation?	The case plan must be developed in consultation with the child and with up to 2 members of the case planning team who are chosen by the child and not the foster parent or case worker. The case plan must indicate that the child should not be in a congregate care setting for longer than one year. The case plan must document an exit strategy from congregate care that meets the needs and service plan of the child. <sup>xi</sup>
What is the plan for transitioning the child out of the facility to a family based setting?	The case plan must indicate the needs that necessitate placement, the plan for transitioning the child to a less restrictive environment, and a projected timeline by which the child will be transitioned. Case plan must be reviewed and updated every 6 months. <sup>xii</sup>

<sup>i</sup> 42 USC §675(1), Welf & Inst. Code §16501.1(d)

<sup>ii</sup> Manual of Policies and Procedures (MPP) 31-420

<sup>iii</sup> Welf. & Inst. Code §§ 11402, 16501.1; MPP 31-206.3

<sup>iv</sup> 42 USC §675(5); Welf & Inst, Code §16501.1(d); MPP 31-420

<sup>v</sup> Welf. & Inst. Code §16501.1(a)(3), (c), (g)(13)

<sup>vi</sup> 45 CFR Part 80; Welf & Inst. Code §§ 165101.1(d), 16001.9; MPP 31-205, 31-420, 31-405.21

<sup>vii</sup> Welf. & Inst. Code §§ 11402(d), 16001.9, MPP 31-420, H & S Code §1503.5, Fam. Code §7911.1

<sup>viii</sup> 42 USC § 675(1)(G); Welf. & Inst. Code §§ 16501.1(d), (g)(8), 16001.9

<sup>ix</sup> Welf.& Inst. Code § 16501.1(g), MPP 31-206.36, 31-405.24

<sup>x</sup> Welf. & Inst. Code §§ 366.21(e)-(g), 366.22, 366.25, 366.3, 366.31, 16501.1(d)-(g)

<sup>xi</sup> 42 USC §675(1)(B); Welf & Inst. Code §§ 16501.1(d)(2)(A), 16010.8; 22 CCR 84022

<sup>xii</sup> Welf. & Inst. Code § 16501.19(d)(2), MPP 31-405.34

This document was created by Youth Law Center and modified by the Judicial Council. The information in this document is based on laws in effect at the time of publication (January 2018). Federal and state laws may change at any time.

# Finding “Families” for Older Youth

Kelly Lynn Beck, Attorney and  
Senior Permanency Trainer

National Institute for Permanent Family Connectedness

# Overview

- Let's see where we're at (group activity)
- What we can cover
  - Unique challenges with older youth;
  - Unpacking those challenges;
    - Grief and Loss issues – how these can prevent youth from actualizing their future;
    - Engagement strategies – no interviews
    - Intentional Strengths conversation – what does that look like?
  - Important Legislative Updates and how they relate to “Permanency”
- Child and Family Team Meetings – Are we ready?

# In case you missed it – AB 403

- Continuing of Care Reform (CCR) signed by Governor in October 2015.
- Implementation is in stages until 2021
- Intent is to have children and youth, who must live apart from their biological parents, live in a permanent home with committed adults, who can meet their needs.
  - Reduce reliance on congregate care, thereby increasing placements in home-based settings
- Finding Relatives/Due Diligence updated
- CFT Meetings required to facilitate case planning and permanency
  - RFA process streamlined

Everybody loves progress  
but nobody likes change



# Why was change necessary?

- “Every day in out-of-home care is a crisis in the life of a child”

Bob Lewis



# When temporary seems to never end...

- Placement becomes the center point of most decisions
- Young people become isolated and lose connections to those who helped form their identity, including siblings
- Young people move from place to place, experiencing losses without any sense of control, resulting in the conclusion that relationships are temporary
- Young people become unfocused, angry, and disruptive. They are diagnosed, medicated and sent farther away from the people who love them, with greater restriction placed on time and access to loved ones. We spend more \$, we call it treatment, and it doesn't work. Then we label the young person a failure and give up.
- Crime, homelessness, dropout, unemployment, unintended pregnancy and other health/well being rates/measures are unacceptable.

# When temporary seems to never end...

- This breeds hopelessness for youth and families, as well as the communities “serve”
- The repeated experience also contradicts the very reasons we entered the field, and the purpose we want to carry into our work on a daily basis.
- The workforce feels frustrated, hopeless and burned out/in, which results in less effective engagement. And families notice...
- Plans and efforts and not personalized or customized, riddled with bias and unfortunate assumption, cookie-cutter reports

# Toxicity of Loneliness and Isolation:

- Associated with poorer physical and emotional outcomes from children through older adults
- Erodes hope and the belief in possibilities
- Reinforces the perspective that “I don’t need anybody”
- Limits the development of social/human capital, which is necessary for successful adult interdependence

# Research re: Isolation & lack of Social Networks

- Poor self esteem resulting in making unwise/potentially harmful choices about their bodies
- Long-term dysfunction socially and physically
- Impaired development of protective factors to improve functioning and resilience when meeting adversity
- Facilitates the development and severity of childhood trauma associated with pathophysiology (e.g. hypertension leading to coronary artery disease)

Child Development and Successful Youth Transitions Committee (2015). Supporting Healthy Sexual Development of Youth in Foster Care. California Child Welfare Council.

Bruskas, D. (2010). "Developmental Health of Infants and Children Subsequent to Foster Care." *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 231-241.  
California Department of Social Services. California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.

Norman, G., Hawkey, L., Ball, A., Berntson, G., & Cacioppo, J. (2013). Perceived Social Isolation Moderates the Relationship between Early Childhood Trauma and Pulse Pressure in Older Adults. *International Journal of Psychophysiology*, 88, 334-38.

# Social Networks and Isolation Research cont'd

- Higher levels of loneliness are associated with:
- Dissatisfaction with living circumstances
- Chronic social stress
- Family conflict
- Poor quality social relationships
- “A person made to feel lonely not only feels unhappy but also feels unsafe, feelings that activate an anachronistic survival mechanism that heightens sensitivity to threats from all sides.”

Cacioppo, J., & Cacioppo, S. (2014). Social Relationships and Health: The Toxic Effects of Perceived Social Isolation. *Social and Personality Psychology Compass*, 8(2), 58-72.

# Research re: Grief and Loss

Ambiguous loss, where losses are not “clear-cut and final” results in:

- Unresolved grief, including outrage and inability to move on
- Confusion, distress and ambivalence
- Blocked coping processes
- Experience of helplessness, and therefore depression, anxiety and relationship conflicts.
- Rigidity of family roles, confusion in boundaries

Lee, R., & Whiting, J. (2007). Foster Children's Expressions of Ambiguous Loss. *The American Journal of Family Therapy*, 35(5), 417-428.

# The Hope for Belonging

“Without stability and continuity within relationships to secure attachment, it is difficult to achieve resolution of painful losses and to actualize a more secure sense of the future”

- D. L. Henry, The 3-5-7 Model: Preparing Children for Permanency, Children and Youth Services Review 27 (2005) 197-212

# Family is Important (“Permanency”)

- Always around
- Close
- Loved
- Security
- Values
- Holidays
- Traditions
- Belonging
- Taught me to love
- Support
- Can depend on them
- Everything
- Connected
- All I know
- Safety
- Unity
- Rock
- Shaped me
- Special
- Framework
- Self-worth
- Permanency
  - Lifelong
  - Forever



# Growing up without Family

- 1 in 4 – incarcerated - 2 years
- Over 1/5th will be homeless at some time
- Only 58% - HS diploma (87% Nationally)
- Less than 3% earn college degree
- Post traumatic stress rate double that of war veterans
- Serious untreated health conditions
- Less likely to be employed
- Poverty level incomes
- Higher rate of becoming victims of crime, or engaging in criminal activity – over 270,000 American prisoners were once in foster care

- From: AFCARS Data, and studies by Courtney, Wulczyn, Hislop, Casey, Child Welfare Information Gateway, 2013; Enhancing Permanency for Youth in Out of Home Care, Fostering Connections. Org; From Place to Place the Movie

# What practices/approaches improve outcomes?

- Active skill building, coaching and training that focuses on the development of adults is effective and essential to promote healthy child development
- Collaborative practice which includes and involves “family” in decision making and determination of planning for kin
- Voice of young people present and apparent in problem-solving and decision making
- Most common factor in evidence-based practices is the quality of relationship between the helper and those being served

# Networks Matter

- Young people are generally better off with their kin than without them
- Healthy development exists within an environment of relationships that begins in the family and extends out to include other adults
- What children need are their *entire* environment of relationships to be invested in their healthy development

# FAMILY CONNECTIONS

“Re-establishing family connections for teens before they exit out of care, no matter what age they are, is the strongest and most positive youth development program the child welfare system can offer...”

\*Avery, Rosemary, Examination of theory and promising practice for achieving permanency for teens before they age out of foster care, 2010



# AB 403 – California

- Codification of recommendation in CDSS report, California Child Welfare Continuum of Care Reform (CCWCCR)
- <http://www.cdss.ca.gov/cdssweb/entres/pdf/CCRLegislativeReport.pdf>
- Brings state into compliance with 2014 Preventing Sex Trafficking and Strengthening Families Act (Public Law 113-183)
  - One of the goals of this legislation was to strengthen the concurrent planning process to achieve better permanency outcomes and
    - To avoid children languishing in foster care for extended periods.

# APPLA

- Only for children 16 and older and non-minor dependents
- “is the last option a county placing agency may recommend to the court” and only after
- Agency has documented all of their efforts to establish a more permanent plan at the time of the permanency hearing

# APPLA

- Is a permanent plan for a youth in an out-of-home foster care placement in which a youth may remain until adulthood, used when following options have been ruled out:
  - Return home;
  - Place with relative;
  - Place for adoption;
  - Tribal customary adoption; and
  - Legal guardianship

# WHEN YOUTH IS IN APPLA

- Agency must document in the case plan:
  - Ongoing and intensive efforts to:
    - Return home, adoption, tribal customary adoption (TCA), legal guardianship or placement with a fit and willing relative
    - Per federal law, efforts must include use of technology including social media to find biological or other family members of the child;
  - During each permanency hearing, the Court is required to:
    - Ask the youth about his or her desired permanency outcome;
    - Make a determination that APPLA is the best permanency plan for the youth and
    - Identify the compelling reasons why it is not in the best interest of the child to return home, be placed in adoption or TCA, guardian or with fit and willing relative



# Fit and Wiling Relative

- Is a permanency option for all youth
- Fit and Willing relative defined as:
  - Approved placement with a “relative” who is willing and capable of proving a stable and permanent home environment for a child but is unable or unwilling to commit to legal permanency through adoption, TCA or Guardianship at the time of the hearing
  - Allow agency to maintain foster youth with relatives who do not wish to adopt or become legal guardians
  - Relatives unwillingness to adopt does not justify the removal of the child from the home if the court finds removal would be seriously detrimental to the child’s emotional well-being

# Fit and Willing Relative

- Agency must continue to provide services that will address the barriers identified by the court to a more stable permanent plan, such as adoption or legal guardianship at subsequent permanency hearings



# Why CFTs? Most fundamental principles

- Child welfare services are most effective when delivered within a child or youth and family-centered, child and family team (CFT);
- CFT shares responsibility to assess, plan, intervene, monitor and refine services over time;
- Process reflects belief that families have the capacity to address their problems and achieve success if given the opportunity and supports to do so;
- CFT meeting must take place within 60 days of removal;
- CFT meeting will be convened to discuss any placement changes and service needs for child or youth;
- Team must be consulted to identify most appropriate placement, always considering the least restrictive.

# Who are the CFT members?

- The Child or Youth
- The Placing Agency Caseworker
- Child or Youth's **Family Members**
- Caregiver
- If eligible, Regional Center Representative
- Youth's tribe or Indian Custodian
- County mental health representative
- FFA or STRTP representative where child is placed
- Formal and informal supports

# Finding “Family” Members

- Included in Due Diligence requirements:
  - Asking youth - Conversations (Engagement)
  - Case Reviews/Case Mining
  - Telephone/e-mail or visit all identified relatives;
  - Asking located relatives for names, location of other relatives
  - Use Internet search tools
- Best Practice in Engaging Older Youth:
  - Connectedness Mapping; Eco Mapping; Remembered People’s Chart;
  - Mobility Mapping; Tree of Life and Others

# Child and Family Team Meetings

- Role – include family members in defining and reaching identified goals for the child;
- Work as a team to identify each family member's strengths and needs to develop a child, youth and family-centered case plan



# It's a Process

- Preparation – IMPORTANT!
- Meeting agenda - Collaborate
- Consider family's ideas before professional suggestions in case plan development;
- Plans must be:
  - Individualized
  - Culturally responsive and
  - Trauma-informed
- Team meeting help recognize when interventions and treatment plans are working and when they need revision

# Typical Strengths List

- When inquiring about Strengths, what are some of the typical responses that you hear?



# Strengths Conversations

Strengths conversations typically lead to abstract descriptions of strengths

*Joanne is a good hokey player, John is a good cook.*

Madsen, 2014

- These strengths are located INTERNALLY to describe who the person is, they are owned by the person.
- These strengths are often received as “nice talk” but not viewed as helpful to the difficulties being addressed.

# Effects of Internal “Strengths” Understandings

- **Diminish sense of personal agency.** Strengths as internal to the person eliminates any intentionality around living into these strengths.
- **Isolate the person.** When strengths are owned by the person then you lose the rich social and relational history related to why people **do** these strengths
- **Discourage diversity.** Abstract strengths owned by the person are typically related to global norms of what is good or positive.

# Intentional Strengths

- Are connected to how people are living into valued ideas for life;
- What they hold as important;
- Space is created to breathe life into strengths offered;
- Questions elicit how the person does this identified strength;
- Is this strength something that can (or already does) assist us in addressing concerns for the youth.

# Practice – Start with one of these questions

- When you are at your best in your work, what are you doing?
- What are your strengths in the work you do?

Bringing a flat strength to life (scaffolding conversations)

**Practices**

→ **Intentions**

→ **Values/Beliefs**

→ **Hopes/Dreams**

→ **Commitments**

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## Resources

- <http://rglewis.com> (Talking with Youth)
- [www.fatherhood.org](http://www.fatherhood.org)
- [www.courtinfo.ca.gov/programs/cfcc](http://www.courtinfo.ca.gov/programs/cfcc)
- [NCJFCJ.org](http://NCJFCJ.org)

## Recommended Title IV-E Findings and Orders

Findings and orders must be based on sufficient supporting evidence, presented to the court by the county agency.

### I. Protective Custody Warrants—dependency cases, include the finding:

A. Continuance in the home is contrary to the child’s welfare.

### II. Detention/Removal Hearings—make the following:

A. Continuance in the home is contrary to the child’s welfare.

B. Temporary placement and care are vested with the social services agency *or* probation department.

C. Reasonable efforts have been made to prevent removal.

### III. Prepermanency Hearings—make the following:

D1. The child’s placement is necessary. The child’s current placement is appropriate.

D2. The agency has complied with the case plan by making reasonable efforts to return the child to a safe home and to complete any steps necessary to finalize the permanent placement of the child.

D3. The extent of progress made toward alleviating or mitigating the causes necessitating placement has been: by the father \_\_\_\_\_, by the mother \_\_\_\_\_, by the child \_\_\_\_\_ (*include child in delinquency proceedings only*).

D4. The likely date by which the child may be returned to and safely maintained in the home or another permanent plan selected is \_\_\_/\_\_\_/\_\_\_.

D7. For child 14 years of age or older: the court finds that the services set forth in the case plan include those needed to assist the child in making the transition from foster care to successful adulthood.

### IV. Permanency Hearing—make the following:

D1. The child’s placement is necessary. The child’s current placement is appropriate.

D2. The agency has complied with the case plan by making reasonable efforts to return the child to a safe home and to complete any steps necessary to finalize the permanent placement of the child.

D3. The extent of progress made towards alleviating or mitigating the causes necessitating placement has been: by the father \_\_\_\_\_, by the mother \_\_\_\_\_, by the child \_\_\_\_\_ (*include child in delinquency proceedings only*).

D5. The plan selected below is appropriate and is ordered:

a. An immediate return to the home is ordered as the permanent plan; *or*

b. The continuation of reunification services and the setting of a further permanency review hearing. *or*

c. Termination of services and:

(1) setting of a Welf. & Inst. Code, § 366.26 or 727.31 hearing; *or*

(2) placement with a fit and willing relative; *or*

(3) placement in foster care with a permanent plan of \_\_\_\_\_ (*specify return home, adoption, tribal customary adoption, legal guardianship, or placement with a fit and willing relative*); *or*

(4) for a child 16 years of age or older, when there is a compelling reason to determine that it is not in the child’s best interest to return home, be placed for adoption or tribal customary adoption, be placed with a legal guardian, or be placed with a fit and willing relative, another planned permanent living arrangement..

D6.  The likely date by which the permanent plan will be achieved or juvenile court jurisdiction will be terminated is \_\_\_/\_\_\_/\_\_\_ *or*

The likely date by which the child may be returned to and safely maintained in the home or another permanent plan selected is \_\_\_/\_\_\_/\_\_\_ (*Use this finding only when the court continues reunification services under D5b.*).

D7. For child 14 years of age or older: the court finds that the services set forth in the case plan include those needed to assist the child in making the transition from foster care to successful adulthood.

### V. Postpermanency Hearing—make the following:

D1. The child’s placement is necessary. The child’s current placement is appropriate.

D2. The agency has complied with the case plan by making reasonable efforts, including whatever steps are necessary to finalize the permanent placement of the child; *or*

(*For a child 16 years of age or older in a planned permanent living arrangement*): the agency has complied with the case plan by making reasonable efforts, including ongoing and intensive efforts to finalize the permanent plan of return home, adoption, tribal customary adoption for an Indian child, legal guardianship, or placement with a fit and willing relative.

D5. The permanent plan selected below is appropriate and ordered:

a. Adoption; *or*  Tribal Customary Adoption; *or*

b. Legal guardianship; *or*

c. Placement with a fit and willing relative; *or*

d. Placement in foster care with a permanent plan of \_\_\_\_\_ (*specify return home, adoption, tribal customary adoption, legal guardianship, or placement with a fit and willing relative*); *or*

e. For a child 16 years of age or older, when there is a compelling reason to determine that it is not in the child’s best interest to return home, be placed for adoption or tribal customary adoption, be placed with a legal guardian, or be placed with a fit and willing relative, another planned permanent living arrangement.

D6. The likely date by which the permanent plan will be achieved or juvenile court jurisdiction will be terminated is \_\_\_/\_\_\_/\_\_\_.

D7. For child 14 years of age or older: the court finds that the services set forth in the case plan include those needed to assist the child in making the transition from foster care to successful adulthood.

## Title IV-E Findings: Legal Citations\*

Revised November 3, 2017

FEDERAL	CALIFORNIA	RESULT IF NO FINDING
Title IV-E of the Social Security Act, 42 U.S.C. § 670 et seq.	<b>Dependency</b> Welf. & Inst. Code, § 300 et seq.	<b>Delinquency</b> Welf. & Inst. Code, § 602 et seq.
<b>Detention/Removal Hearings</b>		
<p><b>A.</b> Court must make finding that continuance in the home of the parent or legal guardian would be contrary to the child’s welfare. (42 U.S.C. § 672(a)(1)-(2).)</p> <p>This finding must be made at the time of the first court ruling authorizing removal of the child from the home. (45 C.F.R. § 1356.21(c).)</p>	<p>Continuance in the home of the parent or legal guardian is contrary to the child’s welfare. (Welf. &amp; Inst. Code, §§ 319(b), 636(d), 11401(b)(3); Cal. Rules of Court, rules 5.678(a)(2), 5.760(c).)</p> <p>This finding must be made at the time of the first court ruling authorizing removal of the child from the home. (Welf. &amp; Inst. Code, §§ 319(c), 636(d)(4).)</p>	<b>Never</b> eligible for title IV-E funding (45 C.F.R. § 1356.21(c).)
<p><b>B.</b> Court must order that placement and care are the responsibility of the state agency or any other public agency with whom the responsible state agency has an agreement. (42 U.S.C. § 672(a)(1)-(2); 45 C.F.R. § 1356.71(d)(1)(iii).)</p>	Temporary placement and care are vested with the child welfare agency pending disposition or further order of court. (Welf. & Inst. Code, §§ 319(e), 636(d)(3)(b); Cal. Rules of Court, rules 5.678(d), 5.760(e)(2), (f)(2).)	No funding until findings are made.
<p><b>C.</b> Court must make finding that reasonable efforts have been made to prevent or eliminate the need for removal. (42 U.S.C. §§ 671(a)(15), 672(a)(1)-(2); 45 C.F.R. § 1356.21(b)(1).)</p> <p>This finding must be made within 60 days of the date of removal. (45 C.F.R. § 1356.21(b)(1).)</p>	Reasonable efforts have been made to prevent or eliminate the need for removal. (Welf. & Inst. Code, §§ 319(d)(1), 636(d)(2)(B), 11401(b); Cal. Rules of Court, rules 5.678(c)(1), 5.760(e)(3).)	<b>Never</b> eligible for title IV-E funding. (45 C.F.R. § 1356.21(b)(1)(ii).)
<b>Case Review/Status Review Hearings—D Findings</b>		
Court must review child’s status and safety no less frequently than once every six months from <b>the date the child entered foster care</b> , in order to make the recommended legal findings as set forth on side two, sections II and IV (42 U.S.C. §§ 671(a)(16), 675(5)(B); 45 C.F.R. §§ 1355.20, 1355.34(c)(2)(ii).)	Periodic status reviews must be held, and the required findings made, no less frequently than every six months, with the first status review being held at the time of the initial dispositional hearing. (Welf. & Inst. Code, §§ 361(e), 366(a), 366.3, 727.2(c), 11400(i), 11404.1; Cal. Rules of Court, rules 5.710(a), 5.810(a).)	Failure to make findings will have financial consequences due to noncompliance with the state plan.
<b>Permanent Plan Hearings—D Findings</b>		
<p>Court must hold a permanency hearing to select a permanent plan no later than 12 months from <b>the date the child entered foster care</b>, and must hold subsequent permanency plan hearings every 12 months thereafter. (45 C.F.R. §§ 1355.20, 1356.21(b)(2)(i); 42 U.S.C. § 675(5)(C), (F).)</p> <p>For a case in which no reunification services are offered, the permanency hearing must be held within 30 days of disposition. (45 C.F.R. § 1356.21(h)(2).)</p>	A permanency planning hearing must be held, and the required findings made, within 12 months from <b>the date the child entered foster care</b> , and subsequent permanency hearings must be held every 12 months thereafter. (Welf. & Inst. Code, §§ 361.5(f), 366.21(f), 366.21(g), 366.22, 366.3, 727.3(a)(1), 11400(j), 11404.1; Cal. Rules of Court, rules 5.715, 5.810(b).)	Funding stops unless findings are made.

**Definition of “date the child entered foster care”:**

**Dependency**—The date the child entered foster care is the earlier of the first finding of child abuse or neglect (jurisdictional finding) or 60 days after the child is physically removed from the home of the parent(s) or legal guardian(s). (Welf. & Inst. Code, § 361.49); Cal. Rules of Court, rule 5.502(9)(A).)

**Delinquency**—The date the minor entered foster care is the date that is 60 days after the date on which the minor was physically removed from the home of the parent(s) or legal guardian(s) unless one of the following exceptions applies: (1) If the minor is detained pending initial foster care placement and remains detained for more than 60 days, then the date of entry into foster care is the date of the hearing at which placement is ordered. (2) If the minor is adjudged a ward; committed to a ranch, camp, school, or other institution; and remains in that facility for more than 60 days prior to placement in foster care, then the date of entry into foster care is the date the minor is physically placed in foster care. (3) If at the time the wardship petition is filed, the minor is a dependent of the juvenile court and in out-of-home placement, then the date of entry into foster care is the earlier of the date the juvenile court made a finding of abuse or neglect, or 60 days after the date on which the minor was removed from his or her home. (Welf. & Inst. Code, § 727.4(d)(4); Cal. Rules of Court, rule 5.502(9)(B).)

\*This chart is based on laws in effect at the time of publication—November 3, 2017. Federal and state laws can change at any time. The chart was compiled by the Judicial Resources and Technical Assistance project of the Center for Families, Children & the Courts, 455 Golden Gate Avenue, San Francisco, California 94102, 415-865-8836.



## Information Sheet 19 Requirements Regarding Relatives

The laws regarding mandatory search, notification, approval process, and placement efforts for relatives have continued to be updated and highlighted. This information sheet consolidates the legal requirements to identify, locate, notice, and engage relatives. These state and federal laws are intended to ensure that children and youth stay connected to safe and healthy relatives and/or to optimize placement opportunities and prevent entry into, or decrease time in, foster care placements.

### **Pre-Detention/Detention**

If a child is taken into temporary custody, the social worker or probation officer must immediately release the child to the custody of a parent, guardian, or relative unless the circumstances in Welfare and Institutions Code sections 309(a) or 628(a) apply.<sup>1</sup>

If, at the detention hearing, the child cannot be returned home, the court must determine if a relative or nonrelative extended family member (NREFM) is able and willing to care for the child.<sup>2</sup> [See sections A and B in attachment] Certain relatives must be given preferential consideration for placement.<sup>3</sup>

*Child Welfare Only: temporary placement*— If the relative or NREFM requests temporary placement, the social worker must initiate an emergency placement pursuant to Welfare and Institutions Code section 361.4.<sup>4</sup> The child may be placed on an emergency basis upon completion of an assessment pursuant to section 361.4, which includes a California Law Enforcement Telecommunications System (CLETS), Child Abuse Central Index (CACI), and walk-through of the home.<sup>5</sup> The social worker must ensure a fingerprint clearance check is done within 10 calendar days of the CLETS or 5-business days of making an emergency placement, whichever is sooner.<sup>6</sup> If the CLETS indicates that the person has a criminal history, the child cannot be placed if there is a non-exemptible conviction. However, a child can be placed for any other conviction once the exemption is granted. A child can also be placed pending an exemption if the director or his or her designee determines it is in the best interest of the child and no party objects.<sup>7</sup>

At the detention hearing, the social worker has a duty to assess any relatives and indicate to the court whether the relatives are able and willing to take temporary custody of the child under section 309 and the assessment under section 361.4. The court must consider the recommendations of the social worker before placing the child with a relative or NREFM. Further, the court must order the parents to disclose

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<sup>1</sup> All further statutory references are to the Welfare and Institutions Code, unless otherwise specified. All further rule references are to the California Rules of Court, unless otherwise specified.

<sup>2</sup> § 319((f)(1)

<sup>3</sup> §§ 319, 319(d)(1)(2) 628.1, 636.

<sup>4</sup> All further statutory references are to the Welfare and Institutions Code, unless otherwise specified.

<sup>5</sup> §§ 309(d) and 361.4(a)

<sup>6</sup> § 361.4(c)

<sup>7</sup> § 361.4

to the social worker the names, residences, and any identifying information of maternal or paternal relatives.<sup>8</sup>

In dependency and delinquency cases, within 30 days of the child being taken into temporary custody, the social worker or probation officer must use due diligence to identify and locate relatives<sup>9</sup> and must provide all adult relatives [See Section A of attachment] notice that the child has been removed from parents and options to participate in the child's care and placement.<sup>10</sup> Therefore, it is imperative that the court inform the agency of this requirement, which will also serve as notice to the parents to work with the agency to provide information about all known family members. The Court may include in its order the agency's duty under this section.

### **Dispositional Hearing**

From detention to disposition, the social services agency and probation department must continue to exercise due diligence by utilizing several search techniques--including internet searches--to identify, locate, and notice relatives and continue the preferential consideration for placement with relatives.<sup>11</sup> The Court may consider those efforts outlined in rules 5.695(g) and 5.790(f) to determine if the agency has exercised due diligence. [See Section C of attachment] At the dispositional hearing, the court must make a finding regarding whether the agency has exercised due diligence to identify and locate relatives.<sup>12</sup>

When a placement in foster care is being made, the proximity of the natural parents for visitation and reunification purposes must be given full consideration and placement must, if possible, be made in the home of a relative, unless the placement would not be in the best interest of the child.<sup>13</sup>

*Child Welfare Only:* The social worker has a continued obligation to assess a relative or NREFM's suitability for emergency placement.<sup>14</sup> The agency must also initiate an assessment under section 361.3 of any relative to be considered for continuing placement.<sup>15</sup>

The dispositional hearing report must address the appropriateness of any relative.<sup>16</sup> The report should identify the efforts utilized by the agency to locate and involve family.

The court can place with a relative if they have:

- Met Resource Family Approval, or

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<sup>8</sup> § 319

<sup>9</sup> Relative is defined within the 5<sup>th</sup> degree in California. This includes parents, stepparents, grandparents, stepparents, siblings, aunts, uncles, nephews, nieces, cousins, great aunts and uncles, great-great grandparents and aunts and uncles, great-great-great grandparents, and relatives by marriage even if marriage ended due to death or divorce.

<sup>10</sup> §§ 309, 628; rule 5.637

<sup>11</sup> §§ 309 and 628

<sup>12</sup> rule 5.695(f)

<sup>13</sup> Family Code Section 7950(a)(1)

<sup>14</sup> § 309

<sup>15</sup> § 319(f)(3)

<sup>16</sup> §§ 358.1, 361.3, 727

- Been assessed for emergency placement (note: section 361.4 requirements do not apply in probation), or
- Meet a compelling reason pursuant to section 16519.5(e).

The Court must also find whether the agency exercised due diligence in identifying, locating, and notifying all relatives.<sup>17</sup> If the dispositional hearing is continued, the court may set a hearing to be held within 30 days from the date of removal or as soon as possible thereafter to consider and determine whether the agency exercised due diligence to identify, locate, and notify the child's relatives.<sup>18</sup>

If the Court finds that the agency has not exercised due diligence, the court may order the agency to conduct an investigation to identify, locate, and notify the child's relatives.<sup>19</sup>

The only exception to notice is if the relative has a personal history of family or domestic violence. This would require additional information from the agency or one of the parties indicating a history or a current restraining order and other relevant evidence.

### **Placement Changes**

After the dispositional hearing, whenever a new placement of the child must be made, consideration for placement shall again be given to relatives who have not been found to be unsuitable and who will fulfill the child's reunification or permanent plan requirements. Social worker must use same requirements as provided under 361.3 and the county social worker shall consider whether the relative has established and maintained a relationship with the child.<sup>20</sup>

### **Reunification Hearings**

Case law in dependency proceedings and state policy through All County Letters indicate that the relative placement preference and duty to assess relatives is required by the agency.<sup>21</sup> During the reunification period, placement with a relative or NREFM can be made as an emergency placement or based on a compelling reason.<sup>22</sup>

### **Permanency and Post-Permanency Hearings**

Under Family Code section 7950 and rule 5.740(b), at any permanency hearing in which the court terminates reunification services, or at any post-permanency hearing for a child not placed for adoption, the court must find that the social worker or probation officer has made diligent efforts to locate an appropriate relative and that each relative whose name has been submitted to the agency has been evaluated.

### **Disrupted or dissolved adoptions – Search for Biological Relatives**

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<sup>17</sup> Rules 5.695, 5.790

<sup>18</sup> Rule 5.695 (e)(f)

<sup>19</sup> Rule 5.695(e)

<sup>20</sup> § 361.3 (d)

<sup>21</sup> *In re Isabelle G* (2016) 246 Cal.App.4<sup>th</sup> 708; ACL 17-65

<sup>22</sup> Welf. & Inst. Codes 361.3, 261.45, 6516.5; DCFS Policy (FYI 17-03)

Whenever a child is returned to the foster care system due to an adoption disruption or set aside, the child welfare agency and any licensed adoption agency may search for a “relative” of a previously adopted child and provide that relative with identifying information about the child, if it is believed that the child’s welfare would be promoted by furnishing this information.<sup>23</sup>

"Relative" includes a member of the child's birth family and NREFMs, regardless of whether the parental rights were terminated, provided that both of the following are true:

(A) No appropriate potential caregiver is known to exist from the child's adoptive family, including NREFMs of the adoptive family.

(B) The child was not the subject of a voluntary relinquishment by the birth parents pursuant to Family Code section 8700 and Health and Safety Code section 1255.7.

*Resources:*

Please see the identifying connections for youth and helping the child find connections charts attached to help in the duty to find family members.

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<sup>23</sup> § 361.3(f); All County Letter No. 08-43

The information in this document is based on laws in effect at the time of publication (January 2018). Federal and state laws may change at any time.

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**SECTION A – IDENTIFICATION AND NOTIFICATION REQUIRED FOR ALL OF THE FOLLOWING [5<sup>th</sup> Degree of Kinship/Relatives]**

PATERNAL (Father) \_\_\_\_\_

MATERNAL (Mother) \_\_\_\_\_

NAME	NOTICED	NEXT STEPS		NAME	NOTICED	NEXT STEPS
			<b>Sibling*</b>			
			<b>Grandparent*</b>			
			<b>Aunt*</b>			
			<b>Uncle*</b>			
			Great-Grandparent			
			Great-Aunt			
			Great-Uncle			
			1 <sup>st</sup> Cousin			
			1 <sup>st</sup> Cousin			
			Great-great-Grandparent			
			Great-great-Aunt			
			Great-great Uncle			
			Spouse or domestic partner of any of the above			
			Extended Family Member			
			Extended tribal family member			

**\*PREFERENTIAL CONSIDERATION FOR PLACEMENT – Adult Sibling, Grandparent, Aunt, Uncle**

**SECTION B – NON-RELATED, EXTENDED FAMILY (NREFM) AND IMPORTANT CONNECTIONS**

<b>RELATIONSHIP</b>	<b>NAME</b>	<b>LOCATED</b>	<b>NEXT STEPS</b>	
Extended Family				
Extended Family				
Godparent				
Neighbor				
Neighbor				
Prior Foster Parent				
Group Home Staff Member				
Teacher				
Teacher				
Coach				
Friend's Parents				
Childhood Friends				
Who does child or youth miss?				

**SECTION C – DUE DILIGENCE – EFFORTS AGENCY - TO BE CONSIDERD BY THE JUDICIAL OFFICER<sup>1</sup>**

Whether social worker has done any of the following:

- Asked the child, in an age-appropriate manner and consistent with the child’s best interest about his relatives
- Obtained information regarding the location of the child’s relatives;
- Reviewed the child’s case file for any information regarding relatives;
- Telephoned, e-mailed or visited all identified relatives;
- Asked located relatives for the names and locations of other relatives;
- Used Internet search tools to locate relatives identified as supports; or
- Developed tools to help the child or parents to identify relatives, including:
  - Genogram – Date Completed: \_\_\_\_\_
  - Family tree – Date Completed: \_\_\_\_\_
  - Family map –Date Completed: \_\_\_\_\_
  - Other diagram of family relationships
    - \_\_\_\_\_
    - \_\_\_\_\_
- Other Efforts
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

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<sup>1</sup> Cal Rule of Court 5.695(f) – Note: not an exhaustive list. Can include any other efforts



# INTENTIONAL STRENGTHS

The National Institute for Permanent Family Connectedness (NIPFC) has produced a number of short articles that articulate essential elements of the Family Finding process. These include [What is Family Finding](#), [Defining Due Diligence](#), and [Quality Relative Internet Searches](#). Over the past two years, NIPFC has increased the emphasis and focus on training that improves the quality of engagement with young people and adults to build robust and energized networks for young people in care and their families. This in turn maximizes the effectiveness of the Family Finding intervention.

This article is authored by Mike Mertz<sup>1</sup>, who cites and invokes effective narrative practices to improve and deepen engagement. More specifically, Mike speaks to the identification and utilization of “Intentional Strengths” as a foundational piece of the engagement and relationship building process. This article speaks to the differentiation between the identification of internal strengths and intentional strengths, and identifies the additional benefits of determining the intentional aspects of strengths while providing guidance as to process of enriching strengths discussions.

Most Child Welfare practice requires the identification of strengths when developing service and treatment plans for the young people and families it serves, in order to create a balanced approach that attends to both the youth and families’ strengths as well as their challenges. The typical strengths discussion is often used as an opportunity to say a couple of nice things about a youth before getting to the real, more difficult issues. A variation of the same, familiar list is often generated: “she is good at basketball”, “he does well at math”, “they help with the younger kids”. These types of strengths are viewed as ‘who the person is’ characteristics and are provided in the abstract. In “Collaborative Helping”, Bill Madsen (2014) describes this type of strengths discussion as:

*When we begin with strengths in the abstract (Joanne is a good hockey player, John is a good cook), we can end up generating a list of strengths that may feel empty and hollow (e.g., Joanne is a good hockey player, but so what? What has that got to do with the problems that brought us here?). These sparse descriptions of strengths can contribute to a sense that strengths discovery is simply happy talk that romanticizes families and doesn’t deal with the tough realities of life. We believe that strengths-based work is too important to let it fall to these stereotypes. (p.126)*

Strengths have long been viewed as being internal in nature; part of a person’s essence. This understanding of strengths as internal can yield positive, though limited, benefits. When one is applauded or recognized for internally based strengths, one may feel good and their connection with those applauding could be enhanced. For these reasons, this type of recognition can still be useful. However, this internalized construction of strengths can also lead to unintended consequences.

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<sup>1</sup> Mike Mertz, MS, is a Director of Staff Development; Co-Leader of Diversity, Equity & Inclusion Organizational Development; as well as an NIPFC Senior Permanency Trainer for the National Institute for Permanent Family Connectedness (NIPFC), Seneca Family of Agencies in Oakland, CA.



Michael White (2007) suggests that internal state understandings of strengths tend to:

- DIMINISH THE SENSE OF PERSONAL AGENCY - When strengths are understood as being “who” the person **is** we risk losing information about **how** and **why** the person **does** these things. It becomes easy to attribute these internal strengths as what they were born with instead of how they have decided to live their lives. This doesn’t allow for an acknowledgement of practices of living according to intentions, purposes, and commitments to life.
- BE ISOLATING - When strengths are viewed as internal to the person, then they are “owned” by that person, they reside within the individual. This is in contrast to intentional practices which are shaped through values and intentions that are shared with others. The “essence” of who someone is {internal language} is encapsulated within the individual while intentions are influenced by one’s community/culture.
- DISCOURAGE DIVERSITY - Strengths offered in the abstract and situated internally are typically connected to global norms around what is valued instead of local (personal and diverse) ideas about what is valued.

In contrast to these traditional internal state understandings, White and Madsen offer a way of understanding strengths from an intentional state. Intentional state understandings of strengths are connected to the **how** people are living into valued ideas for life. Madsen refers to this as understanding strengths as practices. This view denotes action instead of essence. According to White:

*In contrast to internal state conceptions, intentional state conceptions of identity are distinguished by the notion of “personal agency.” This notion casts people as active mediators and negotiators of life’s meanings and predicaments, both individually and in collaboration with others. (p 103).*

When viewing strengths as how people live out what they hold as important, the old and familiar strengths lists tend to come alive. Instead of merely generating a list of words, space is created to breathe life into what has been offered. For example, when one is asked to share a strength for a youth and they state “he is a caring person”, we would typically just write CARING up on the board and move on to the next strength. What we are interested in is how the person **does** CARING. We want to know if this CARING is something that can (or already does) assist the group in addressing the concerns that they are facing.

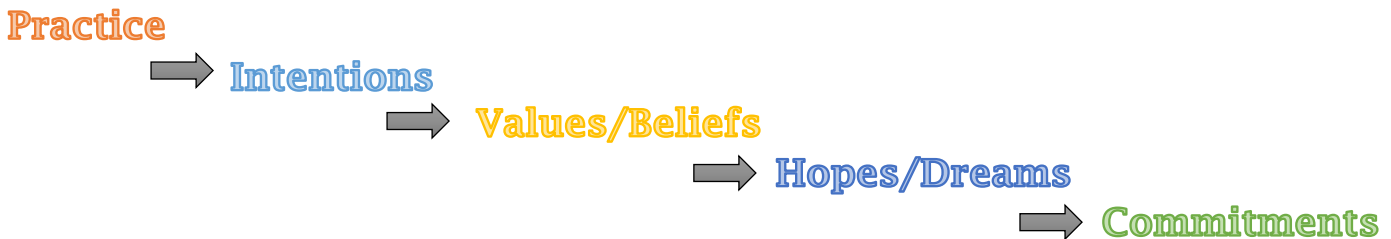
The way to bring these flat strengths to life is by asking questions. Borrowing from Vygotsky’s (1986) work, White (2007) proposed the idea of scaffolding conversations in the development of intentional state understandings of strengths. Madsen (2014) applied these ideas to community based/wraparound type practices. The questions we ask will allow you to move from the abstract strengths to intentions for life that has a past, present and future. This type of inquiry opens space to connect these intentions, hopes, values and practices to the lives of others. One is able to arrive at richly described strengths that position the youth as an active participant in moving toward their preferred life

The following is an example of scaffolding a strengths conversation held with a group of social workers at a training. They were asked to identify strengths they had related to how they engage kids and families that they work for. The strength of “respect” was identified:

- When you are engaging with “respect” what is it that you are doing? How do you **do** “respect”? If I were to watch you talking with folks while connected to this “respect”, what would I notice? What are the **practices** that go into doing “respect”?
- Why is it that you choose to be connected to “respect-doing” when engaging with youth and families? What are your **intentions** in engaging from a position of “respect”?

- What **values or beliefs** are these intentions grounded in? Are these values and beliefs that you have held for a long time or are they a more recent discovery?
- What **hopes and dreams** for the families you work for and/or for yourself do these values and beliefs reflect? Are these values and beliefs connected to particular hopes and dreams that you have for the people you serve or for yourself?
- What might these intentions, values and beliefs, hopes and dreams indicate about what you are **committed** to or stand for in your work life? What might all of this tell me about what you are committed to when it comes to engaging families?

This conversation does not have to take more than a couple of minutes but allows us to land on functional strengths that are connected to a history of intentional behaviors. The questioning moves from the identification of:



Sometimes strengths are not offered as adjectives in the abstract but are skills that don't seem applicable to the situation that needs to be addressed. How many times has "good basketball player", "excellent artist", or "he helps his brother with his homework" shown up on a strengths list? Although these are admirable and already stated as practices, they might not seem connected to helping a youth who is perhaps struggling with substance mis-use, truancy, or is stuck in the foster care system. We can apply the same kind of inquiry previously discussed but first we have to get an intentional understanding of these practices. Let's take the example of "she's good at basketball" as an identified strength. Questions designed to understand the practices, intentions and values associated with being good at basketball, which can yield a richer understanding and better utilization of the strength moving forward. Questions can include:

Q: What about basketball are you good at? (Could also be; what about basketball do you enjoy?)

A: I'm good at defense and I'm a pretty good shooter.

Q: What are the skills or knowledge that goes into being 'good at defense'?

A: It's all about hustle and effort. I learned that you have to stay between the person you're guarding and the basket.

Q: Are hustle and effort things that are important to you on the basketball court?

A: Yes. Without hustle and effort you can't be good at defense.

We now have identified some intentions (hustle and effort), some knowledge (staying between the person you are guarding and the basket) and some hopes or desires (to be good at defense is important to the youth). We have allowed the youth to name these things in words that fit for her instead of offering up some ideas that may seem distant to her experience.

Some additional questions to ask from here include:

- How do you do hustle and effort in basketball?
- When you are connected to hustle and effort what are you doing?
- If I were to watch you play basketball, how would I know when you were engaged in hustle and effort, what would I see you doing?
- What is it about being good at defense that is important to you?
- Where or from whom did you learn this value? Do they know that you learned this from them? What might it mean to them to know that they contributed to your life in this way?
- I wonder if your acknowledgement of their contribution might have an impact on them. If so, what impact might that be?

Sometimes it makes sense to engage the person who has offered a strength about someone else. For example, in a family team meeting someone might suggest about a youth that “he is caring”.

Following are some possible questions to ask of the person who offered up the strength:

- What have you noticed that tells you he is caring? How does he show this caring? Do you have a story of him doing this caring?
- When he is doing this caring, what do you believe his intentions are? Why do you suppose he lives a caring lifestyle?
- What might he hold as important or give value to when engaging in this caring? When you see him caring for others what does this tell you about his values?
- Where do you think he hopes this caring will take him in life? Do you think this caring is an indication of any hopes or dreams he might have for his future or the future of others?

Is there any more evidence of these hopes, values, or intentions that you can share with us? Do you know if there are others who wouldn't be surprised to hear you describe him as caring? What do they know about him or have seen him do that would lead them to see caring as an accurate description?

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In summary, the research has taught us that conducting Family Finding simply to find someone to place a young person with is not an effective strategy and may be a misuse of the intervention. Family Finding recognizes the moral and social obligation to involve healthy and caring family members in the lives of those who may or have entered the system, as well as the mounting evidence which declares that we recognize family as the experts who are best equipped to solve their problems.

Future articles will further detail engagement practices and tools to enhance the quality of the relationship building with those the system is designed to serve, along with an update about the reasonable efforts required by law for child welfare agency staff to consistently provide, especially in regards to engagement with relatives, fathers and also in establishing paternity.

For more information, resources and a list of trainings provided by NIPFC, please go to [www.familyfinding.org](http://www.familyfinding.org).

Madsen, W. & Gillespie, K. (2014). *Collaborative Helping: A Strengths Framework for Home-Based Services*. Hoboken, NJ: John Wiley & Sons, Inc.

Vygotsky, L. (1986). *Thought and Language*. Cambridge, MA: MIT Press.

White, M. (2007). *Maps of Narrative Practice*. New York, NY/London, England: W.W. Norton & Company.

# HOW “REASONABLE EFFORTS” LEADS TO EMOTIONAL AND LEGAL PERMANENCE

BOB FRIEND AND KELLY BECK

“Hidden within the landmark legislation were two words that, over the years, would come to summarize the expectations of the law, typify its vagueness, and predict its controversy—‘reasonable efforts.’”<sup>1</sup>

## I. ABOUT THE AUTHORS

The authors of this article, Bob Friend, LCSW, and Kelly Beck, JD, collectively have over sixty years of experience working with children, youth, and families.<sup>2</sup> They have each spent the majority of their professional careers dedicated to learning, training, coaching, and inspiring “permanency.”<sup>3</sup> For the last six years, they have worked together at the National Institute of Permanent Family Connectedness (NIPFC)<sup>4</sup> to train and coach professionals in child welfare agencies, court systems, and other partner agencies on how to reduce the time youth spend in care, increase

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<sup>1</sup> Wendy Whiting Blome, *Reasonable Efforts, Unreasonable Effects: A Retrospective Analysis of the “Reasonable Efforts” Clause in the Adoption Assistance and Child Welfare Act of 1980*, 23 J. SOC. & SOC. WELFARE 133, 134 (1996). See also 42 U.S.C. § 671(a)(15)(B)(i)–(ii) (2012) (“[R]easonable efforts shall be made to preserve and reunify families—prior to the placement of a child in foster care, to prevent or eliminate the need for removing the child from the child’s home; and to make it possible for a child to safely return to the child’s home . . .”).

<sup>2</sup> See *Trainer and Staff Bios*, NAT’L INST. FOR PERMANENT FAM. CONNECTEDNESS, <http://www.familyfinding.org/trainings/trainer-bios.html> [https://perma.cc/JF25-4H74].

<sup>3</sup> See *More About Family Finding*, NAT’L INST. FOR PERMANENT FAM. CONNECTEDNESS, <http://www.familyfinding.org/moreaboutfamilyfinding.html> [https://perma.cc/QS3T-3YF9] (“Although physical legal permanence is an explicit outcome for most cases, Family Finding defines permanency as a state of permanent belonging, which includes knowledge of personal history and identity, as well as a range of involved and supportive adults rather than just one legal resource.”); *NRCPCF Web-based Practice Toolkits*, NAT’L RESOURCE CTR. FOR PERMANENCY & FAM. CONNECTIONS, <http://www.nrcpfc.org/projects-and-products.html> [https://perma.cc/MCD5-L2UY].

<sup>4</sup> See *generally* NIPFC, NAT’L INST. FOR PERMANENT FAM. CONNECTEDNESS, <http://familyfinding.org> [https://perma.cc/A5VN-H65H].

permanency outcomes, and involve “family”<sup>5</sup> early and often in permanency planning.<sup>6</sup>

Both Bob and Kelly have witnessed, first hand, how child welfare systems<sup>7</sup> have come together in an effort to create better outcomes for the families and youth they serve.<sup>8</sup> They have witnessed how one person can affect a child’s travel through the child welfare system by being relentless in the quest for permanency.<sup>9</sup> It is with great pleasure and pride that the authors submit this article to all professionals who work within the child welfare system. It is their hope that this article will be informative and inspirational for those professionals as well as others newly introduced to or aspiring to work within the child welfare system.

## II. INTRODUCTION

This article intends to holistically review the opportunities and actions of the entire child welfare system in order to improve the experience and outcomes of the children and families it was intended to serve. More specifically, the authors will weave together the leadership and oversight provided by courts via reasonable efforts findings with the innovative practices that child welfare agencies, advocates, and partners can take in between hearings to advance and secure the safety, permanence, and well-being of the children, parents, family members, and communities they serve.<sup>10</sup>

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<sup>5</sup> As used throughout this article, the term “family” includes all biological family members, important connections for children and youth, non-related extended family members, and others. As used in Indian Child Welfare Act (ICWA) matters, “family” also includes “extended family member[s].” 25 U.S.C. § 1903 (2012).

<sup>6</sup> See generally *NIPFC Trainings*, NAT’L INST. FOR PERMANENT FAM. CONNECTEDNESS, [http://www.familyfinding.org/trainings/trainings\\_NIPFC.html](http://www.familyfinding.org/trainings/trainings_NIPFC.html) [https://perma.cc/A3R3-EPW9].

<sup>7</sup> “Child welfare systems” refer to child welfare agencies, judicial officers, court personnel, attorneys, court appointed special advocates (CASA), service providers, parents, and children. See *How the Child Welfare System Works (Fact Sheet)*, COMPREHENSIVE YOUTH SERVICES FRESNO (May 8, 2012), <http://cysfresno.org/how-the-child-welfare-system-works-fact-sheet> [https://perma.cc/7R6M-HN24].

<sup>8</sup> The authors have worked with communities in Pennsylvania, Virginia, Wisconsin, and California among others. These communities have brought together their legal, child welfare, probation, service providers, and foster family agencies to develop Family Finding and Engagement strategies. See Children’s Home Society of North Carolina, *York County Family Finding Conference*, VIMEO (2013), <https://vimeo.com/64070556> [https://perma.cc/T6DG-3PTA].

<sup>9</sup> Based upon personal accounts shared by attendees during field trainings conducted by both authors.

<sup>10</sup> CHILD WELFARE INFO. GATEWAY, *How the Child Welfare System Works* 1 (Feb. 2013), <https://www.childwelfare.gov/pubpdfs/cpswork.pdf> [https://perma.cc/H7C8-LD8G].

The article will begin by reviewing some of the history of the reasonable efforts requirements and further clarify the true intent of this enabling legislation,<sup>11</sup> followed by discussion of how the child welfare system has often missed the opportunities contained within the vague definition of the requirements.<sup>12</sup> The authors will then outline how the court can ensure that the “efforts” presented include the identification, engagement, and involvement of family members.<sup>13</sup> The article will further describe the types of efforts or innovative child welfare practices that have been created to improve relationships with youth, parents, and family members by increasing their trust in and promoting their partnership with the child welfare system.<sup>14</sup> These practices are designed to resolve the safety issues that prevent children from leaving foster care, while attending to the loneliness and lack of permanency options for many children in care.

The proposed “reasonable efforts” methodology (hereinafter methodology) presented in this article focuses on what can be accomplished between each of the hearings where a reasonable efforts finding is required, so that the child or youth is moving closer to being connected with and raised within a committed, supportive, permanent family.<sup>15</sup> Viewing the time between hearings as an opportunity to implement evidence-based and promising family engagement strategies will allow the court to more effectively review all efforts employed to create a pathway home for each child or youth.

Finally, the article will detail the responsibilities and opportunities for key child welfare system participants to contribute to the identification, engagement, and involvement of family members in the matters concerning their kin.<sup>16</sup> Their activities toward this goal should be presented to the court as evidence of reasonable efforts.

#### *A. Clarifying Reasonable Efforts*<sup>17</sup>

In 1980, Congress passed the Adoption Assistance and Child Welfare Act (The Act).<sup>18</sup> The Act sought to address several issues that Congress

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<sup>11</sup> See *infra* Sections II.A, II.B.

<sup>12</sup> See *infra* Sections II.C, II.D.

<sup>13</sup> See *infra* Sections II.D, II.E.

<sup>14</sup> See *infra* Section II.E, Part III.

<sup>15</sup> See *infra* Part III.

<sup>16</sup> See *infra* Part IV.

<sup>17</sup> In ICWA matters, the term “active efforts” is used to describe remedial services, rehabilitative programs, and preventive measures. See 25 U.S.C. § 1912(d) (2012).

<sup>18</sup> Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (1980) (codified in scattered sections of 42 U.S.C.).

deemed to be lacking in the child welfare system.<sup>19</sup> Some of the important issues addressed by the Act were: the unnecessary placement of children into the care of the state;<sup>20</sup> children languishing in care;<sup>21</sup> the challenges in achieving permanency for children;<sup>22</sup> and the lack of essential due process afforded to the parents in state intervention matters.<sup>23</sup> The due process standards outlined therein included the use of fundamental fairness in a planned and reasonable manner to further the goals of child permanency and effective judicial oversight.<sup>24</sup> Courts were now required to find that the state<sup>25</sup> had employed reasonable efforts at different critical stages of the child welfare proceedings in order to maximize permanency options for children.<sup>26</sup>

This legislation marked the first time that the federal government sought to define the role and responsibilities of the state.<sup>27</sup> It was also the first time that the courts were charged with determining whether the public child welfare agency (hereinafter agency) had provided services or “efforts” that would meet the needs of the child, while also monitoring the time that children were spending in care.<sup>28</sup>

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<sup>19</sup> See, e.g., J. Leonard P. Edwards, *Achieving Timely Permanency in Child Protection Courts: The Importance of Frontloading the Court Process*, 58 JUV. & FAM. CT. J. 1, 2 (2007); Alice C. Shotton, *Making Reasonable Efforts in Child Abuse and Neglect Cases: Ten Years Later*, 26 CAL. W. L. REV. 223, 223–24 (1990).

<sup>20</sup> Edwards, *supra* note 19, at 1–3; Shotton, *supra* note 19, at 223–24.

<sup>21</sup> Edwards, *supra* note 19, at 2.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> J. Leonard Edwards, *Reasonable Efforts: A Judicial Perspective*, JUDGES’ PAGE NEWSL. 5, 5 (Oct. 2007), [http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0710\\_reasonable\\_efforts\\_in\\_the\\_dependency\\_court\\_issue\\_0119.pdf](http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0710_reasonable_efforts_in_the_dependency_court_issue_0119.pdf) [<https://perma.cc/LQ25-J26L>].

<sup>25</sup> “State child welfare agencies” are defined as:

State agencies that are mandated to respond to reports of child abuse and neglect and to intervene as needed to protect the child. Typically, they provide a range of child welfare services for children and families, including family preservation, child protection, out-of-home care, and adoption.

*Glossary* – S, CHILD WELFARE INFO. GATEWAY, <https://www.childwelfare.gov/glossary/glossarys> [<https://perma.cc/G2SF-S2PR>].

<sup>26</sup> Edwards, *supra* note 24, at 5.

<sup>27</sup> Laura Argys & Brian Duncan, *Economic Incentives and Foster Child Adoption*, 50 DEMOGRAPHY 933, 935 (2013).

<sup>28</sup> Elisa Kawam, *Revisiting the Adoption Assistance and Child Welfare Act of 1980: Analysis, Critique, and Recommendations*, 1 WORLD J. SOC. SCI. RES. 23, 26–27 (2014).

The enactment of the reasonable efforts requirement, coupled with the explicit judicial gatekeeping requirement, resulted in confusion and frustration for those working within the child welfare system.<sup>29</sup> Contributing to this confusion was the Act's lack of a definition of the term "reasonable efforts,"<sup>30</sup> along with the absence of a recognized universal standard for the term.<sup>31</sup>

Since the Act's passage, many publications, both private and public, have sought to provide guidance or clarification for practitioners.<sup>32</sup> Indeed, one such publication by the U.S. Department of Health and Human Services (HHS) offered an explanation as to why there is no definition.<sup>33</sup> For our purposes, it is critical to consider the strength of the language contained within one paragraph of that publication:

We do not intend to define "reasonable efforts." To do so would be a direct contradiction of the intent of the law. The statute requires that reasonable efforts determinations be made on a case-by-case basis. We think any regulatory definition would either limit the courts' ability to make determinations on a case-by-case basis or be so broad as to be ineffective.<sup>34</sup>

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<sup>29</sup> Blome, *supra* note 1, at 138; Kawam, *supra* note 28, at 30; Ernestine S. Gray, *Judicial Viewpoints on ASFA*, in *CTR. FOR THE STUDY OF SOC. POLICY, UBRAN INST., INTENTIONS AND RESULTS: A LOOK BACK AT THE ADOPTION AND SAFE FAMILIES ACT 60, 60* (2009), <http://affcn.org/wp-content/uploads/IntentionsandResults.pdf> [<https://perma.cc/XZF5-NP7J>].

<sup>30</sup> See *supra* note 1 and accompanying text; Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews, 63 Fed. Reg. 50,058, 50,061 (Sept. 18, 1998).

<sup>31</sup> David J. Herring, *The Reasonable Efforts Requirement—A Critique and a Proposal*, *JUDGES' PAGE NEWSL.* 20 (Oct. 2007), [http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0710\\_reasonable\\_efforts\\_in\\_the\\_dependency\\_court\\_issue\\_01119.pdf](http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0710_reasonable_efforts_in_the_dependency_court_issue_01119.pdf) [<https://perma.cc/LQ25-J26L>].

<sup>32</sup> MARK HARDIN ET AL., *A SECOND COURT THAT WORKS: JUDICIAL IMPLEMENTATION OF PERMANENCY PLANNING REFORMS* (1995); ABA PRESIDENTIAL WORKING GRP. ON THE UNMET LEGAL NEEDS OF CHILDREN AND THEIR FAMILIES, *AMERICA'S CHILDREN AT RISK: A NATIONAL AGENDA FOR LEGAL ACTION* (1993); MARK HARDIN, *ESTABLISHING A CORE OF SERVICES FOR FAMILIES SUBJECT TO STATE INTERVENTION: A BLUEPRINT FOR STATUTORY AND REGULATORY ACTION* (1992); NAT'L COUNCIL OF JUVENILE & FAMILY COURT JUDGES ET AL., *MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER* (1987); DEBRA RATTERMAN ET AL., *REASONABLE EFFORTS TO PREVENT FOSTER PLACEMENT: A GUIDE TO IMPLEMENTATION* (2d ed. 1987).

<sup>33</sup> Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews, 63 Fed. Reg. 50,058, 50,073 (Sept. 18, 1998), <https://www.gpo.gov/fdsys/pkg/FR-1998-09-18/pdf/98-24944.pdf> [<https://perma.cc/H527-BJDF>].

<sup>34</sup> *Id.*



The publication further provided examples that could be used by courts in determining what “efforts” could be considered by the judicial officer:

In the absence of a definition, courts may entertain actions such as the following in determining whether reasonable efforts were made:

- (1) Would the child's health or safety have been compromised had the agency attempted to maintain him or her at home?
- (2) Was the service plan customized to the individual needs of the family or was it a standard package of services?
- (3) Did the agency provide services to ameliorate factors present in the child or parent, i.e., physical, emotional, or psychological, that would inhibit a parent's ability to maintain the child safely at home?
- (4) Do limitations exist with respect to service availability, including transportation issues? If so, what efforts did the agency undertake to overcome these obstacles?
- (5) Are the State agency's activities associated with making and finalizing an alternate permanent placement consistent with the permanency goal? For example, if the permanency goal is adoption, has the agency filed for termination of parental rights, listed the child on State and national adoption exchanges, or implemented child-specific recruitment activities?<sup>35</sup>

At the state level, legislators often sought to define reasonable efforts in order to comply with the federal guidelines and assist practitioners.<sup>36</sup> Many of the resulting state statutes, however, focused on describing the literal meaning of the two words: “reasonable” and “efforts.” For example, in Missouri, “‘Reasonable efforts’ means the exercise of reasonable diligence and care by the division to utilize all available services related to meeting the needs of the juvenile and the family,”<sup>37</sup> whereas, in Florida,

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<sup>35</sup> *Id.*

<sup>36</sup> Will L. Crossley, *Defining Reasonable Efforts: Demystifying the State's Burden Under Federal Child Protection Legislation*, 12 B.U. PUB. INT. L.J. 259, 262 (2003).

<sup>37</sup> MO. REV. STAT. § 211.183(2) (2010).

“‘reasonable effort’ means the exercise of reasonable diligence and care by the department to provide the services ordered by the court or delineated in the case plan.”<sup>38</sup>

These state-legislated definitions and most others include the term “services.”<sup>39</sup> Services have been defined as efforts on behalf of the public child welfare agency to help the parent overcome the reasons for the removal.<sup>40</sup> However, these definitions provide little or no guidance regarding what efforts or services could or should be considered by the courts.

Only a few states have taken the additional step of drafting legislation or policy that includes examples of specific efforts for the judicial officer to consider and to which the child welfare agency should adhere.<sup>41</sup> For example, California has developed both statutes and rules of court that further assist the judicial officer in making this determination.<sup>42</sup>

The California Welfare and Institutions Code includes language that outlines the efforts a child welfare worker is required to employ prior to the physical removal of a child from his or her home. These efforts include:

- (1) Whether there are any reasonable services available to the worker which, if provided to the minor’s parent[s], guardian, caretaker, or to the minor, would eliminate the need to remove the minor from the custody of his or her parent, guardian, or caretaker.
- (2) Whether a referral to public assistance . . . would eliminate the need to take temporary custody of the minor. If those services are available they shall be utilized.
- (3) Whether a nonoffending caretaker can provide for and protect the child from abuse and neglect and whether the alleged perpetrator voluntarily agrees to withdraw from the residence, withdraws from the residence, and is likely to remain withdrawn from the residence.<sup>43</sup>

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<sup>38</sup> FLA. STAT. ANN. § 39.521(1)(f)(1) (West 2012).

<sup>39</sup> See MO. REV. STAT. § 211.183(2) (2010); FLA. STAT. ANN. § 39.521(1)(f)(1) (West 2012); ALASKA STAT. § 47.10.086(a) (2014); IOWA CODE ANN. § 232.102(10) (2014); MINN. STAT. §§ 260.012(a), 260C.301(b)(5) (2015).

<sup>40</sup> See 42 U.S.C. § 629a(a)(7)(B) (2012).

<sup>41</sup> See CAL. WELF. & INST. CODE §§ 319(a)–(b), 362–370 (West 2016); 42 U.S.C. § 601(a) (2012); HEALTH & HUMAN SERVS. AGENCY, CAL. DEP’T. OF SOC. SERVS., Manual of Policies and Procedures: Child Welfare Services § 31-066 (1993) <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/cws1.PDF> [<https://perma.cc/F4DN-R7G3>].

<sup>42</sup> CAL. WELF. & INST. CODE § 306(b) (West 2016); CAL. RULES OF COURT § 5.676(a) (2013).

<sup>43</sup> CAL. WELF. & INST. CODE § 306(b)(1)–(3) (West 2016).

The California Rules of Court provide additional guidance for judicial officers, including what other efforts could be implemented *prior* to physical removal.<sup>44</sup> Likewise, these rules contain guidance when the child or youth has nonetheless been physically removed from his or her home after unsuccessful attempts.<sup>45</sup> In that instance, “information about any parent or guardian of the child with whom the child was not residing at the time the child was taken into custody and about any relative or nonrelative extended family member . . . with whom the child may be detained” must be provided to the court.<sup>46</sup>

These Rules of Court contain the court’s requirement to determine whether the child welfare agency has made reasonable efforts to prevent physical removal, and if continued physical removal is warranted, then whether there is an appropriate relative, close family friend, or another adult with whom the child can be placed.<sup>47</sup> This course of action would avoid placement with someone the child does not know or trust.<sup>48</sup>

For dependency cases involving domestic violence, the National Council of Juvenile and Family Court Judges (NCJFCJ) has published a checklist to assist judges in identifying specific factors that should be considered when making reasonable efforts determinations in situations involving domestic violence.<sup>49</sup> Some of the recommended efforts in these cases include: “Helping the adult victim find a family member or friend to stay with temporarily”; “Enlisting the support of community entities such as churches, schools, and other neighborhood organizations”; and “Providing interpreters.”<sup>50</sup>

If the child is already removed, the NCJFCJ checklist suggests “the court should ask what actions would be needed to allow the child to return home immediately and safely and what services would be needed to support the child’s return.”<sup>51</sup> Included in these recommendations is a notation to judicial

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<sup>44</sup> JUDICIAL COUNCIL OF CAL., JUDICIAL COUNCIL GOVERNANCE POLICIES 7 (2008), [http://www.courts.ca.gov/documents/appendix\\_d.pdf](http://www.courts.ca.gov/documents/appendix_d.pdf) [<https://perma.cc/4MCH-UE8N>]. This guidance includes a “description of the services that have been provided . . . and of any available services or safety plans that would prevent or eliminate the need for the child to remain in custody”). CAL. RULES OF COURT § 5.676(b)(2) (2016).

<sup>45</sup> CAL. RULES OF COURT § 5.678(a)–(b) (2013).

<sup>46</sup> CAL. RULES OF COURT § 5.676(b)(5) (2016).

<sup>47</sup> CAL. RULES OF COURT § 5.678(c)–(e) (2013).

<sup>48</sup> CAL. RULES OF COURT § 5.678(e) (2013).

<sup>49</sup> LEIGH GOODMARK, NAT’L COUNCIL OF JUVENILE & FAMILY COURT JUDGES, REASONABLE EFFORTS CHECKLIST FOR DEPENDENCY CASES INVOLVING DOMESTIC VIOLENCE 25 (2008), <http://www.thegreenbook.info/summit/documents/rechecklist.pdf> [<https://perma.cc/2EMS-PT5N>].

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 26.

officers that the list of questions and services is not exhaustive. “In every case, the services that the adult victim will need to keep herself or her child safe will be different” and “[j]udges should also ensure that services are culturally competent, linguistically appropriate, and sensitive to the particular concerns of immigrant communities.”<sup>52</sup>

It is clear the federal government has granted courts the authority to determine what types of efforts would be appropriate, available, and reasonable for a particular family or youth.<sup>53</sup> Implicit within this authority is the court’s obligation to consider any relevant evidence that would determine whether the reasonable efforts requirement has been met for a specific family or youth.<sup>54</sup> Specific facts and circumstances of each individual case and family situation help to define reasonable efforts in each instance. With risk assessment tools used by the Child Welfare Agency to determine if removal is necessary, the family’s strengths and needs are determined and provided to the court.<sup>55</sup> Without this information, a judicial officer cannot make an accurate or reliable reasonable efforts finding. In that instance, the court should ask for additional information.<sup>56</sup> In many, if not most cases, this knowledge of familial and cultural background must be

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<sup>52</sup> *Id.*

<sup>53</sup> See J. LEONARD EDWARDS, REASONABLE EFFORTS: A JUDICIAL PERSPECTIVE 22 (2014) (ebook), <http://www.ncjfcj.org/resource-library/publications/reasonable-efforts-judicial-perspective> [https://perma.cc/T9SM-995R].

<sup>54</sup> See *id.* at 48–50.

<sup>55</sup> NAT’L COUNCIL OF JUVENILE & FAMILY COURT JUDGES, ENHANCED RESOURCE GUIDELINES: IMPROVING COURT PRACTICE IN CHILD ABUSE AND NEGLECT CASES 131 (2016) [hereinafter ENHANCED RESOURCE GUIDELINES], <http://www.ncjfcj.org/sites/default/files/%20NCJFCJ%20Enhanced%20Resource%20Guidelines%2005-2016.pdf> [https://perma.cc/F478-9J8Z]. See also *id.* at 135 (“Does the family believe that these services, interventions, and supports will meet their current needs and build upon strengths?”). Likewise, in determining whether the current out-of-home placement meets the child’s and family’s needs, the NCJFCJ provides:

Kinship caregivers should be approached from a strengths-based perspective by addressing their current situation and evaluating current and known safety risks along the same lines that child safety is evaluated to determine whether the child can return to a parent’s care. Non-relative foster care placement should be a last resort, and even if a child is placed in foster care, maintaining a connection with relatives who are important to the child and supportive of the parents is essential.

*Id.* at 137, 138.

<sup>56</sup> See EDWARDS, *supra* note 53, at 22.

obtained through conversations and engagements with the family and the youth.<sup>57</sup>

As alluded to above, what is *most* important to understand about the reasonable efforts requirement is that it is, by design and necessity, a moving target. Given the unique circumstances, needs, and strengths of each family, it must be flexible and pliable. It is a term that allows the court to consider all reasonable means available, at a particular point in time and that can be utilized to achieve an end result.<sup>58</sup> With the continued emergence and development of new and innovative child welfare practices, it behooves practitioners to insist on a specific, concrete, and “one size fits all” definition of reasonable efforts. As HHS has pointed out, the states “have a great deal of flexibility in satisfying this requirement . . . for demonstrating that judicial determinations are made on a case-by-case basis.”<sup>59</sup> With each new or redesigned program or practice made available to child welfare agencies comes the potential to broaden what efforts the judicial officer may consider to be reasonable.

*“The reasonable efforts finding is as an important an element of the case as a finding on abuse or neglect.”*<sup>60</sup>

#### *B. When Reasonable Efforts Are Required*<sup>61</sup>

A reasonable efforts finding is required at specific or federally mandated court hearings in a child welfare case.<sup>62</sup> These written findings are typically found in a pre-drafted template and completed after each hearing where the finding is required.<sup>63</sup> Often there is a box contained within this form that the judicial officer (or court clerk) will check once the hearing is complete.<sup>64</sup>

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<sup>57</sup> See ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 68, 122; NAT’L COUNCIL OF JUVENILE & FAMILY COURT JUDGES, RIGHT FROM THE START: THE CCC PRELIMINARY PROTECTIVE HEARING BENCHCARD 161 (2011) [hereinafter BENCHCARD], [http://www.ncjfcj.org/sites/default/files/CCC%20Benchcard%20Study%20Report\\_1.pdf](http://www.ncjfcj.org/sites/default/files/CCC%20Benchcard%20Study%20Report_1.pdf) [https://perma.cc/ZQ8W-EUC8].

<sup>58</sup> See 42 U.S.C. § 671(a)(15) (2012).

<sup>59</sup> Title IV-E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews, 65 Fed. Reg. 4020, 4056 (Jan. 25, 2000).

<sup>60</sup> YOUTH LAW CTR., MAKING REASONABLE EFFORTS: A PERMANENT HOME FOR EVERY CHILD 40 (2000), [http://www.nccourts.org/Citizens/CPrograms/Improvement/Documents/making\\_reasonable\\_effort.pdf](http://www.nccourts.org/Citizens/CPrograms/Improvement/Documents/making_reasonable_effort.pdf) [https://perma.cc/ZP83-W8ZS].

<sup>61</sup> There are situations where no reasonable efforts are required. See 42 C.F.R. § 1356.21(b)(3) (2012). Under the ICWA, “active efforts” must be utilized to prevent the breakup of the Indian family, whether in a foster care placement or in termination of parental rights proceedings. See 25 U.S.C. § 1912(d), (f) (2012).

<sup>62</sup> See 42 U.S.C. § 671(a)(15)(2012); 45 C.F.R. § 1356.21 (2012).

<sup>63</sup> EDWARDS, *supra* note 53, at 1415–22.

<sup>64</sup> See *id.*

Some jurisdictions utilize a form that allows the court to fill in what efforts have been employed by the child welfare agency.<sup>65</sup>

Most often, the only evidence presented during a hearing where a reasonable efforts finding is required consists of what “services” the agency has provided or tried to provide for the child’s parent(s). Thereafter, the parent submits his or her compliance records in response to those services. The timing of the reasonable efforts finding is strategic because the court must consider efforts made prior to the child being removed from the home, at the time of removal, and in consideration of permanency goals.<sup>66</sup>

The first hearing when a reasonable efforts finding is required is the first time the court is introduced to the child and family.<sup>67</sup> This hearing is sometimes referred to as the “Shelter Care Hearing,” however it is identified as different titles depending on the jurisdiction, including “preliminary protective,” “detention,” or “emergency removal.”<sup>68</sup> This is, by far, the most crucial finding made by the judicial officer.<sup>69</sup> The finding is actually based on a two-prong test.<sup>70</sup> The court must find that the state made reasonable efforts to (1) prevent the unnecessary removal of the child from his or her home and (2) “effect the safe reunification of the child and family (if temporary out-of-home placement is necessary to ensure the immediate safety of the child).”<sup>71</sup>

The evidence required at this hearing focuses on what was done in the field to prevent removal and what measures can be employed to enable the child to immediately return home.<sup>72</sup> Furthermore, the information or evidence that the court relies upon to make this finding must be “explicitly documented and must be made on a case-by-case basis and so stated in the court order.”<sup>73</sup> As suggested by the example language from the California statutes and rules of court, these efforts should include what resources and family involvement can be implemented to allow the child to remain at home.<sup>74</sup>

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<sup>65</sup> *Id.* at 1422.

<sup>66</sup> *See* 42 U.S.C. § 671(A)(15) (2012).

<sup>67</sup> ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 107.

<sup>68</sup> *Id.*; BENCHCARD, *supra* note 57, at 6–7.

<sup>69</sup> EDWARDS, *supra* note 53, at 318–19.

<sup>70</sup> 45 C.F.R. § 1356.21(b) (2012).

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> 45 C.F.R. § 1356.21(d) (2012).

<sup>74</sup> *See* CHILD WELFARE INFO. GATEWAY, REASONABLE EFFORTS TO PRESERVE OR REUNIFY FAMILIES AND ACHIEVE PERMANENCY FOR CHILDREN 7–8 (2016), <https://www.childwelfare.gov/pubPDFs/reunify.pdf> [<https://perma.cc/8YJN-Z6DY>].

The next hearing where a reasonable efforts finding is required<sup>75</sup> is the first federally mandated review hearing.<sup>76</sup> According to the federal regulations, the court must review the child's situation no less than once every six months from the date of entry into foster care.<sup>77</sup> Finally, the court is required to determine whether the agency has or has not made reasonable efforts to finalize the permanent plan for the child, such as whether the plan is reunification, adoption, legal guardianship, placement with a fit and willing relative, or placement in another planned permanent living arrangement.<sup>78</sup>

It cannot be stressed enough that each time the court makes a determination regarding whether reasonable efforts have been made, it must be done so on a case-by-case basis.<sup>79</sup> The rationale for this requirement is found within the question and answer section in the Child Welfare Policy Manual developed and maintained by the Children's Bureau, Administration for Children and Families, within HHS.

[The basis for] this policy can be found in the legislative history of the Federal foster care program. The Senate report on the bill [that became Public Law 96-272] characterized the required judicial determinations as “. . . important safeguard[s] against inappropriate agency action . . .” and made clear that such requirements were not to become “. . . a mere *pro forma* exercise in paper shuffling to obtain Federal funding . . .” We concluded, based on our review of State[] documentation of judicial determinations over the past years, that, in many instances, these important safeguards had become precisely what Congress was concerned that they not become.<sup>80</sup>

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<sup>75</sup> It should be noted that some states have incorporated the “reasonable efforts” determination into other interim review hearings and at dispositional hearings. See EDWARDS, *supra* note 53, at 377.

<sup>76</sup> CAL. RULES OF COURT § 5.810(a) (2016) (“For any ward removed from the custody of his or her parent or guardian under section 726 and placed in a home under section 727, the court must conduct a status review hearing no less frequently than once every six months from the date the ward entered foster care.”).

<sup>77</sup> 45 C.F.R. § 1355.20 (2012) (“The date of the first judicial finding that the child has been subjected to child abuse or neglect; or, the date that is 60 calendar days after the date on which the child is removed from the home pursuant to § 1356.21(k).”)

<sup>78</sup> 45 C.F.R. § 1356.21(b)(2)(i) (2012).

<sup>79</sup> 45 C.F.R. § 1356.21(d) (2012).

<sup>80</sup> Title IV-E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews, 65 Fed. Reg. 4020, 4056 (Jan. 25, 2000) (internal citations omitted).

The focus of the methodology proposed by this article centers on what is being done in between each of these critical hearings to ensure the child or youth is moving toward being connected to and raised within a family, so that his or her stay in foster care can be prevented or minimized. Viewing these periods as opportunities to build upon the services already being provided along with the use of innovative, effective family engagement strategies will allow the court to review all efforts made to achieve stable permanency for each child or youth.<sup>81</sup>

*“That undefined prescript has come to dominate practice with profound impact on the lives of children, families, social workers, administrators, judges, and attorneys in the child welfare system. The drafters of the legislation never suspected that the reasonable efforts clause would become the key mechanism for enforcing the intent of the law.”*<sup>82</sup>

### C. Missed Opportunities

The child welfare system is typically defined as a state intervention, utilized when parents abuse, neglect, or abandon their children.<sup>83</sup>

When a state intervenes with a family, the state may decide to leave the child in the home while providing services necessary to protect the child’s safety. But, where the state believes that risks existing in the home are too high, the state’s intervention can include removing the child from the home and placing the child in the *temporary* custody of the state.<sup>84</sup>

Recent national statistics captured by the Children’s Bureau cited 112,584 children in foster care for two or more years as of September 30, 2014, whereas approximately 22,392 aged out of foster care in 2014.<sup>85</sup> Given

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<sup>81</sup> “Effective family engagement strategies” include family-centered casework practice and family-centered practice. See *Glossary – F*, CHILD WELFARE INFO. GATEWAY, <https://www.childwelfare.gov/glossary/glossaryf> [<https://perma.cc/4P7J-N9GP>]; *More About Family Finding*, NAT’L INST. FOR PERMANENT FAM. CONNECTEDNESS, <http://familyfinding.org/moreaboutfamilyfinding.html> [<https://perma.cc/SR9Q-VH89>].

<sup>82</sup> Blome, *supra* note 1, at 134.

<sup>83</sup> See CHILD WELFARE INFO. GATEWAY, DEFINITIONS OF CHILD ABUSE AND NEGLECT 1 (June 2014), <https://www.childwelfare.gov/pubPDFs/define.pdf> [<https://perma.cc/HP5Q-H782>].

<sup>84</sup> Crossley, *supra* note 36, at 265 (emphasis added).

<sup>85</sup> U.S. DEP’T OF HEALTH & HUMAN SERVICES, ADMIN. FOR CHILDREN & FAMILIES, THE AFCARS REPORT: PRELIMINARY FY 2014 ESTIMATES AS OF JULY 2015, at 2–3 (2015)



the poor outcomes for youth who age out of foster care,<sup>86</sup> it is important that the child welfare system be utilized as a *temporary* intervention with a goal of returning or maintaining the child at home or another permanent family-like living arrangement.<sup>87</sup> Federal legislation and guidelines promote the use of promising and evidence-based practice, along with relative engagement strategies, to reduce lengths of stay in foster care and promote permanency.<sup>88</sup> The following review of how the child welfare system should respond to families and children in crisis, as well as how innovative practices can improve outcomes for this population, will help demonstrate the benefits of the methodology proposed later in this article.

The progression of events once the child welfare system has responded to a report of child maltreatment is as follows:

The goal of state intervention is to take those steps necessary to prevent or eliminate the need for removal of the child from the home or to make it possible for the child to return safely home when removed. The child protection agency must show that it has made “reasonable efforts” in meeting the case plan before removing the child or permitting the child to return home.<sup>89</sup>

Child welfare professionals typically interpret this definition of the state’s intervention as the provision of “services” to the parent or guardian

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[hereinafter AFCARS REPORT], <http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf> [<https://perma.cc/48RF-RXP2>].

<sup>86</sup> See generally NAT’L YOUTH IN TRANSITION DATABASE, COMPARING OUTCOMES REPORTED BY YOUNG PEOPLE AT AGES 17 AND 19 IN NYTD COHORT (2014); GRETCHEN RUTH CUSICK ET AL., CRIME DURING THE TRANSITION TO ADULTHOOD: HOW YOUTH FARE AS THEY LEAVE OUT-OF-HOME CARE (2011).

<sup>87</sup> See Overview, CHILD WELFARE INFO. GATEWAY (2013) [hereinafter Overview], <https://www.childwelfare.gov/topics/outofhome/overview> [<https://perma.cc/2XTK-QD4K>].

Out-of-home care is intended to be temporary—the goal is to return children home as soon as possible or achieve permanency with another permanent family when this is not possible. Many of the services provided to children in out-of-home care and their families are targeted to achieving the goal of permanency.

*Id.*

<sup>88</sup> CHILD WELFARE INFO. GATEWAY, ENGAGING FAMILIES IN CASE PLANNING 7 (Sept. 2012), [https://www.childwelfare.gov/pubPDFs/engaging\\_families.pdf](https://www.childwelfare.gov/pubPDFs/engaging_families.pdf) [<https://perma.cc/N94J-6ZEY>].

<sup>89</sup> J. Richard Fitzgerald et al., *Using Reasonable Efforts Determinations to Improve Systems and Case Practice in Cases Involving Family Violence and Child Maltreatment*, 54 JUV. & FAM. CT. J. 97, 97 (2003).

from whom the child was removed.<sup>90</sup> A review of the allegations for removal is then coupled with services to ameliorate those conditions.<sup>91</sup> However, the “case plan” as mentioned within this definition should also include the child or youth’s case plan. It should ultimately include a case plan that will enable the child to return home or achieve permanency with another family.

During this period focused on reunification and the provision of services toward that goal, the child welfare worker usually meets with the parent(s) once a month to determine how they are progressing in meeting the requirements of their case plan.<sup>92</sup> A typical discussion between the child welfare worker and parent(s) may include: how many clean tests have been received; how many meetings, therapy appointments, or parenting classes were attended; and an update on visitation.

The parent(s) may also meet with their attorney to determine legal strategies or perhaps struggles or obstacles in meeting the requirements of their case plan.<sup>93</sup> The attorney for the child is required to conduct his or her own separate investigation while meeting with the child at least once a month.<sup>94</sup> A court appointed special advocate (CASA) may meet with the parents while spending as much time as possible with the child or youth.<sup>95</sup> Other service providers—such as parenting instructors, mental health professionals, substance abuse counselors, or domestic violence counselors—may meet with the parent(s) and child to assist them in meeting their case plan requirements.<sup>96</sup>

In addition to the above mentioned tasks, the child welfare worker is responsible for finding an appropriate placement for the child.<sup>97</sup> The child welfare worker spends an enormous amount of time finding the first temporary placement, as well as looking for a new placement if the first one

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<sup>90</sup> *Id.* at 103.

<sup>91</sup> *Overview, supra* note 87.

<sup>92</sup> CHILD WELFARE INFO. GATEWAY, SUPPORTING REUNIFICATION AND PREVENTING REENTRY INTO OUT-OF-HOME CARE 6 (Feb. 2012), <https://www.childwelfare.gov/pubPDFs/srpr.pdf> [<https://perma.cc/LBX5-EFSF>].

<sup>93</sup> AM. BAR ASS’N, STANDARDS OF PRACTICE FOR ATTORNEYS REPRESENTING PARENTS IN ABUSE AND NEGLECT CASES 10, [http://www.americanbar.org/content/dam/aba/administrative/child\\_law/ParentStds.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/child_law/ParentStds.authcheckdam.pdf) [<https://perma.cc/J3XQ-ESPL>].

<sup>94</sup> *See, e.g.*, AM. BAR ASS’N, STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES 7 (1996), [http://www.americanbar.org/content/dam/aba/migrated/family/reports/standards\\_abuseneglect.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/migrated/family/reports/standards_abuseneglect.authcheckdam.pdf) [<https://perma.cc/Q8MT-48RD>].

<sup>95</sup> *See id.* at 8.

<sup>96</sup> *See id.*

<sup>97</sup> *Id.* at 7.

fails.<sup>98</sup> The lack of approved foster families in many communities, which has often been described as a national crisis, makes it extremely challenging and stressful for many child welfare workers to find placements for children who have been removed from their homes.<sup>99</sup>

Some jurisdictions have embraced, either voluntarily or as a result of litigation, the use of “child and family teams” that bring together family members, other supportive individuals in the community, and professional service providers to help create a “comprehensive” continuum of care for the family.<sup>100</sup> Unfortunately, the implementation of “child and family teams” often looks remarkably similar to the practice that preceded it, with various professionals making up the majority of team members.<sup>101</sup> The resulting lack of youth and family voice at the table does not conform to the intent and principles of the practice model or to the requirements of the legal settlements.<sup>102</sup>

Rather than applying all of its “efforts” or “services” toward removing those factors that brought the child and family to the attention of the child welfare system, the system should also be focused on involving “family” in a meaningful and deliberate fashion.<sup>103</sup> The stakeholders in child welfare, including the courts need to ask themselves: “How can we involve family early and often to ensure we are meeting our reasonable efforts requirements to prevent removal, to facilitate return home, and to finalize a permanent plan for the family.”

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<sup>98</sup> UNIV. OF CAL. DAVIS EXTENSION, CTR. FOR HUMAN SERVS., A LITERATURE REVIEW OF PLACEMENT STABILITY IN CHILD WELFARE SERVICE: ISSUES, CONCERNS, OUTCOMES AND FUTURE DIRECTIONS 11 (2008), <http://www.childsworld.ca.gov/res/pdf/PlacementStability.pdf> [<https://perma.cc/AVS7-UAVC>].

<sup>99</sup> Sarah Fay Campbell, *Retention, Not Recruitment, Key to Foster Parent Shortage*, NEWNAN TIMES-HERALD (Aug. 17, 2016, 12:25 PM), <http://times-herald.com/news/2016/08/retention-not-recruitment-key-to-foster-parent-shortage> [<https://perma.cc/743H-EK4R>]; Anabel Munoz, *LA County Experiencing Shortage of Foster Parents; Thousands of Kids Need Homes*, ABC NEWS (May 2, 2016), <http://abc7.com/family/la-county-experiencing-shortage-of-foster-parents;-thousands-of-kids-need-homes/1319736> [<https://perma.cc/Y6LC-H996>].

<sup>100</sup> First Amended Complaint for Declaratory and Injunctive Relief at 4, *Katie A. v. Bontá*, No. 02-056662 (C.D. Cal. Dec. 20, 2002), <http://www.bazelon.org/LinkClick.aspx?fileticket=zV5vRdozQrY%3d&tabid=186> [<https://perma.cc/MH7C-KR2A>].

<sup>101</sup> *See, e.g.*, SAUL SINGER, CHILD AND FAMILY TEAM MEETINGS: NEVADA CASE PLANNING AND ASSESSMENT POLICIES 5, [https://www.childwelfare.gov/pubPDFs/resources/NV\\_CaseManagementTrainingFacilitator.pdf](https://www.childwelfare.gov/pubPDFs/resources/NV_CaseManagementTrainingFacilitator.pdf) [<https://perma.cc/VX27-P2BE>].

<sup>102</sup> *See id.* at 10.

<sup>103</sup> *See id.* at 8.

*D. Filling in the Gaps*

Since the passage of the Act in 1980, the child welfare system has failed in many ways to adhere to the spirit of the legislation.<sup>104</sup> Subsequent federal legislation has been passed to fill in the gaps of missed opportunities or where statute has failed to clearly delineate that family and youth should be involved at all stages of the “temporary” child welfare process.<sup>105</sup>

In 1997, Congress passed the Adoption and Safe Families Act (ASFA) due to concerns that implementation as outlined in the Act was not occurring, resulting in a growing number of children being raised in foster care without permanency.<sup>106</sup> ASFA sought to maintain the family unit and prevent the unnecessary removal of a child, effect the expeditious reunification of the child who is in temporary out-of-home placement, and effect an alternative permanency goal in a timely manner.<sup>107</sup> This legislation notably introduced the concept and terminology of “Concurrent Planning.”<sup>108</sup>

In 2006, Congress passed the Child and Family Services Improvement Act.<sup>109</sup> This federal legislation required the court (or court approved administrative body) conducting a required permanency hearing for a foster child to consult with him or her in an “age-appropriate manner” regarding

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<sup>104</sup> Nat’l Coal. for Child Prot. Reform, *The Unreasonable Assault on “Reasonable Efforts,”* in ISSUE PAPERS ON FAMILY PRESERVATION, FOSTER CARE AND REASONABLE EFFORTS (2015), <http://www.nccpr.org/reports/9Efforts.pdf> [<https://perma.cc/2PHT-MD72>]; Theodore J. Stein, *The Adoption and Safe Families Act: How Congress Overlooks Available Data and Ignores Systemic Obstacles in Its Pursuit of Political Goals*, 25 CHILD. & YOUTH SERV. REV. 669, 672 (2003), [http://ac.els-cdn.com/S0190740903000665/1-s2.0-S0190740903000665-main.pdf?\\_tid=47827a66-9ac8-11e6-afbe-00000aab0f26&acdnat=1477409746\\_a5864f6cfd573a91c35e0a53a72ff3f6](http://ac.els-cdn.com/S0190740903000665/1-s2.0-S0190740903000665-main.pdf?_tid=47827a66-9ac8-11e6-afbe-00000aab0f26&acdnat=1477409746_a5864f6cfd573a91c35e0a53a72ff3f6) [<https://perma.cc/Q3NA-DCB6>].

<sup>105</sup> See Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.) (providing funding in part for the provision of technical assistance to support the goal of effecting more adoptions, including models fast tracking children under the age of one year); Child and Family Services Improvement Act of 2006, Pub. L. No. 109-288, 120 Stat. 1233 (codified in scattered sections of 42 U.S.C.) (providing funding in part for the purposes of coordinated child and family services programs and addressing the increased prevalence of methamphetamine and its impact on children in the foster care system); Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. 110-351, 122 Stat. 3949 (2008) (providing funds in part for the purpose of establishing an updated transition plan for children aging out of the foster care system).

<sup>106</sup> Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (1997).

<sup>107</sup> Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 101, 111 Stat. 2115, 2116 (1997).

<sup>108</sup> Adoptions and Safe Families Act of 1997, Pub. L. No. 105-89, § 473A(i)(2)(B), 111 Stat. 2115, 2124 (1997).

<sup>109</sup> Child and Family Services Improvement Act of 2006, Pub. L. No. 109-288, 120 Stat. 1233 (2006).

the proposed plan to find a permanent home for the child or help the child transition to independent living.<sup>110</sup>

In 2008, the Fostering Connections to Success and Increasing Adoptions Act was passed.<sup>111</sup> There are many components of this major legislation, but for our purposes, the main modification to the current structure of the child welfare system is that now the “State” is required to identify and notice relatives when a child is removed from the home.<sup>112</sup> These requirements were grounded in research that children experience better outcomes if they are placed with or connected to kin, rather than languishing in care that was found in many cases to be harmful to children.<sup>113</sup> The law also required states to make reasonable efforts to place siblings removed from their home in the same foster care, adoption, or guardianship placement, or facilitate visitation or ongoing contacts with those who cannot be placed together, unless it is contrary to the safety or well-being of any of the siblings.<sup>114</sup>

In 2011, the Child and Family Services Improvement and Innovation Act was passed.<sup>115</sup> This legislation required states to describe what activities they will implement to reduce the length of time that children under the age of five are without a permanent family.<sup>116</sup>

Then in 2014, the passage of the Preventing Sex Trafficking and Strengthening Families Act eliminated the use of Another Planned Permanent Living Arrangement (APPLA) for children under the age of 16 and severely restricted its usage for youth 16 and older.<sup>117</sup> It further authorized children 14 and older to participate in the development of their

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<sup>110</sup> Child and Family Services Improvement Act of 2006, Pub. L. No. 109-288, § 10, 120 Stat. 1233, 1255 (2006).

<sup>111</sup> Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949 (2008).

<sup>112</sup> Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 103(3)(A)–(B), 122 Stat. 3949, 3956 (2008).

<sup>113</sup> See, e.g., CHILD FOCUS & N. AM. COUNCIL ON ADOPTABLE CHILDREN, KINSHIP ADOPTION: MEETING THE UNIQUE NEEDS OF A GROWING POPULATION 12 (2010), [http://childfocuspartners.com/wp-content/uploads/CF\\_Kinship\\_Adoption\\_Report\\_v5.pdf](http://childfocuspartners.com/wp-content/uploads/CF_Kinship_Adoption_Report_v5.pdf) [<https://perma.cc/ZZ5C-V7LV>].

<sup>114</sup> Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 206(3)(A)–(B), 122 Stat. 3949, 3962 (2008).

<sup>115</sup> Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, 125 Stat. 369 (2011).

<sup>116</sup> Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(a)(3)(C), 125 Stat. 369, 369 (2011).

<sup>117</sup> Preventing Sex Trafficking and Strengthening Families Act, Pub. L. No. 113-183, §§ 112, 475A, 128 Stat. 1919, 1926–27 (2014).

own case plans, including consultation with up to two members of a “case planning team.”<sup>118</sup>

Despite the ongoing efforts to encourage and promote timely attainment of permanence via judicial oversight and to ensure increased family involvement and promotion of youth and family voice, children still unnecessarily languish in care, are aging out without sufficient supports, and are living unhealthy lifestyles once leaving care.<sup>119</sup> Despite the steep reduction in child welfare intake and total enrollment in child welfare nationally, the number of youth aging out did not reflect the same decline proportionately, and in fact increased over this eight year period, prior to the establishment nationally of extending foster care beyond eighteen via the Fostering Connections Act.<sup>120</sup>

Adoption and Foster Care Statistics, United States, 1940–2015<sup>121</sup>

Year	Entered	Total Enrollment	Aged Out
2004	298,087	517,000	23,121
2005	307,173	513,000	24,407
2006	304,872	510,000	26,517
2007	293,233	491,000	29,730
2008	280,423	463,792	29,516
2009	255,027	420,415	29,471

<sup>118</sup> Preventing Sex Trafficking and Strengthening Families Act, Pub L. No. 113-183, § 113, 128 Stat. 1919, 1928 (2014).

<sup>119</sup> See PEW CHARITABLE TRUSTS, TIME FOR REFORM: AGING OUT AND ON THEIR OWN MORE TEENS LEAVING FOSTER CARE WITHOUT A PERMANENT FAMILY 5–6 (2007) [hereinafter AGING OUT], [http://www.pewtrusts.org/~media/legacy/uploadedfiles/wwwpewtrustsorg/reports/foster\\_care\\_reform/kidsawaitingtimeforreform0307pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/wwwpewtrustsorg/reports/foster_care_reform/kidsawaitingtimeforreform0307pdf.pdf) [https://perma.cc/F66F-XDEY].

<sup>120</sup> Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949 (2008).

<sup>121</sup> See Wm. Robert Johnston, *Historical Statistics on Adoption in the United States, Plus Statistics on Child Population and Welfare*, JOHNSTON’S ARCHIVE (Oct. 15, 2016), <http://www.johnstonsarchive.net/policy/adoptionstats.html> [https://perma.cc/8DRG-LCN7].

2010	255,278	405,330	27,854
2011	251,388	397,885	26,286
<b>Avg</b>	280,685	464,803	27,113

A key step necessary to close this gap is to increase the partnership, interaction, and accountability of both the judicial and service branches within the child welfare system. This will create an alignment that will not only meet legislative intent, but will improve the experience of those who are served by the system, as well as prevent unnecessary entries and reduce the length of stay in the system.

#### *E. The Shift*

How do we move away from the status quo of prioritizing stable but temporary shelter, foster, and group placement to a more consistent attainment of the legislative intent to promote family involvement and timely permanence with family? It can be argued the lack of national accountability of both child welfare agencies and courts (i.e., lack of attention in IV-E court audits to meeting requirements for family finding, family involvement, and youth participation), along with archaic funding streams that allow or even promote divided efforts, work to discourage system participant collaboration.<sup>122</sup> And while efforts are underway to re-visit child welfare funding,<sup>123</sup> measures can be taken immediately and within the current system to move closer, and faster, to the desired outcomes.

Individuals can begin an immediate shift in their daily practice by establishing a default thought process of family involvement.<sup>124</sup> The focus of the courts and professionals providing or overseeing service delivery to young people and their families must embrace the notion that the primary and most undervalued asset available are the very families they are obligated

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<sup>122</sup> CHILDREN'S DEF. FUND, RECOMMENDATIONS FOR FINANCING CHILD WELFARE MADE BY THE PEW COMMISSION ON CHILDREN IN FOSTER CARE 6-8 (2004), [http://cdf.childrendefense.org/site/DocServer/pew\\_financing\\_recommendations.pdf?docID=791](http://cdf.childrendefense.org/site/DocServer/pew_financing_recommendations.pdf?docID=791) [<https://perma.cc/4DCP-TZQP>].

<sup>123</sup> See, e.g., *New Georgia Law Creates Major Reforms for Child Welfare*, UNITED METHODIST CHILD. HOME (May 16, 2015), <http://www.umchildrenshome.org/2015/05/14/new-georgia-law-creates-major-reforms-for-child-welfare> [<https://perma.cc/M5D3-VXXP>].

<sup>124</sup> "Families" refers to healthy and safe family members, including those defined in note 5, *supra*.

to serve. Family members can play a variety of roles to help avert unnecessary out of home placements, to minimize and heal trauma, to limit loneliness and disconnection, and to maintain a sense of hope in the face of crisis.<sup>125</sup> They can work together with child welfare professionals and volunteers to restore acceptable functioning of birth parents in order to reunify or support the establishment of strong relationships with kin.<sup>126</sup>

The court, as the system's gatekeeper and overseer of the agency's efforts both before entering care and continuing throughout the child or youth's participation in the child welfare system,<sup>127</sup> has the responsibility to ensure that all available efforts (models) that promote family involvement are being implemented.<sup>128</sup> Thus, the court can utilize its authority to ensure that the agency has met its legal mandates (i.e., preventing removal, return home or permanency planning) by supporting and requiring family involvement, while also authorizing the participation of all stakeholders in these efforts which will ultimately assist in reaching these overarching goals for each child.

The court is required to make specific reasonable efforts findings and it must do so by reviewing and considering all relevant evidence.<sup>129</sup> This evidence can be viewed as the "key" to permanency, since these findings and orders will ultimately determine the path the child will follow.<sup>130</sup> Children and youth need to be surrounded by a network of loving people where they can feel loved, secure, and safe, as well as provided with a sense of belonging.<sup>131</sup> Minimizing disconnection from their "support system" and reducing the time away from "family" should be the priority.<sup>132</sup> The practice models discussed below, along with each of their components, are an indication of what can be accomplished outside the courtroom to move children closer to permanency.<sup>133</sup> The checklist attached as Appendix A is a shorthand version of these programs which can be used a checklist during each hearing where reasonable efforts is required.<sup>134</sup>

If all child welfare professionals commit to the attainment of certain and specific legal mandates early and often, while utilizing innovative child welfare practices that promote safety, permanence, and well-being, each

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<sup>125</sup> See Rose Marie Wentz & Kelly Lynn Beck, *Unlocking "Reasonable Efforts" Kinship is Key*, 46 CLEARINGHOUSE REV. 99, 105–107 (2012).

<sup>126</sup> See *id.*

<sup>127</sup> Edwards, *supra* note 19, at 2.

<sup>128</sup> Wentz & Beck, *supra* note 125, at 112.

<sup>129</sup> ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 302–07.

<sup>130</sup> Edwards, *supra* note 19, at 10.

<sup>131</sup> See ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 109.

<sup>132</sup> *Id.*

<sup>133</sup> See *infra* Section III.B.

<sup>134</sup> See Appendix A.



child or youth's chances for early and safe permanency will be greatly enhanced.<sup>135</sup> Safety, permanence, and well-being can be viewed as a three-legged stool where the intersecting constructs rely on the stability of each leg. When children and adults are not well connected, they are vulnerable to experiencing both physical and psychological challenges.<sup>136</sup>

Human and social capital research indicates that supportive networks provide alternatives to and discouragement from delinquency.<sup>137</sup> Young people who age out of foster care without social and emotional supports are subject to a plethora of poor outcomes, many of which have been cited by numerous studies in order to drive system reform.<sup>138</sup> When foster youth are able to develop relationships characterized by trust and commitment, their outcomes during and after placement are greatly improved.<sup>139</sup> This is especially true when children and their caregivers are assisted in building or accessing a supportive network of family members that can be there for them over the long term. When young people have at least some connection to their parents, along with a close relationship with grandparents, they suffer from fewer emotional and behavioral problems and develop better social skills that help reduce aggressive behavior on the part of the young person.<sup>140</sup>

The work being done inbetween the hearings where reasonable efforts is required must be geared toward family involvement, placement, and support. This is the evidence needed for the judicial officer to make a "reasonable efforts" finding.<sup>141</sup>

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<sup>135</sup> See generally Edwards, *supra* note 19. See also Wentz & Beck, *supra* note 125, at 101.

<sup>136</sup> John T. Cacioppo & Stephanie Cacioppo, *Social Relationships and Health: The Toxic Effects of Perceived Social Isolation*, 8 SOC. & PERSONALITY COMPASS 58, 58 (2014), <http://onlinelibrary.wiley.com/doi/10.1111/spc3.12087/epdf> [<https://perma.cc/2PCL-BPCN>].

<sup>137</sup> Mikaela J. Dufur et al., *Examining the Effects of Family and School Social Capital on Delinquent Behavior*, 36 DEVIANT BEHAV. 511, 515 (2015), <http://www.tandfonline.com/doi/pdf/10.1080/01639625.2014.944069?needAccess=true> [<https://perma.cc/6DLW-TCRY>].

<sup>138</sup> MARK E. COURTNEY ET AL., MIDWEST EVALUATION OF THE ADULT FUNCTIONING OF FORMER FOSTER YOUTH: OUTCOMES AT AGE 26, at 13-17 (2011), [https://www.chapinhall.org/sites/default/files/Midwest%20Evaluation\\_Report\\_4\\_10\\_12.pdf](https://www.chapinhall.org/sites/default/files/Midwest%20Evaluation_Report_4_10_12.pdf) [<https://perma.cc/J8Y9-AB7B>]; Ruth Massinga & Peter J. Pecora, *Providing Better Opportunities for Older Children in the Child Welfare System*, 14 FUTURE CHILD. 150, 151 (2014), [http://futureofchildren.org/publications/docs/14\\_01\\_FullJournal.pdf](http://futureofchildren.org/publications/docs/14_01_FullJournal.pdf) [<https://perma.cc/UQD5-JSNN>].

<sup>139</sup> Delilah Bruskas, *Developmental Health of Infants and Children Subsequent to Foster Care*, 23 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 231, 231 (2010), <http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6171.2010.00249.x/epdf> [<https://perma.cc/88S8-23M3>].

<sup>140</sup> Ann Lukits, *Grandparent Power: Bonds with Seniors Help Stabilize Teens*, WALL STREET J. (Aug. 31, 2016, 11:41 AM), <http://www.wsj.com/articles/grandparent-power-bonds-with-seniors-help-stabilize-teens-1441035672> [<https://perma.cc/E7L8-2CAW>].

<sup>141</sup> See *supra* note 35 and accompanying text.

## III. OVERVIEW OF PROPOSED APPROACH

The goal of the proposed reasonable efforts methodology is to incorporate the latest and most innovative, family-focused child welfare practices, which are designed to build a supportive network for the youth and family and intertwine those practices with a sound legal approach.<sup>142</sup> This will generate more of a “family as the solution” approach to child welfare work. The listed innovative practices are particularly effective in engaging and involving family members.<sup>143</sup> These practices are designed to proactively reach out to family members, invite them to participate in planning for the future of their kin, and welcome them to the resulting process of discussion and problem-solving.<sup>144</sup> It is important to note that there are other programs and processes that support family involvement, and if those programs include some of the same components as the practices described in this article, they too should be included in reasonable efforts discussions and activities.<sup>145</sup>

It is posited that the best practice model presented here would prevent unnecessary removals, safely maintain a child’s sense of belonging with family without unnecessary disruptions, and establish a more seamless process of maintaining family connections.<sup>146</sup> The proposed methodology not only embraces and incorporates other family-focused legislative requirements, such as fostering connections,<sup>147</sup> relative placement preference,<sup>148</sup> and concurrent planning,<sup>149</sup> but it helps child professionals and the courts to meet those requirements.<sup>150</sup>

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<sup>142</sup> JIM CASEY YOUTH OPPORTUNITIES INITIATIVE, SOCIAL CAPITAL: BUILDING QUALITY NETWORKS FOR YOUNG PEOPLE IN FOSTER CARE 1–2, [http://www.lawyersforchildrenamerica.org/matriarch/documents/Issue\\_Brief\\_Social\\_Cap.pdf](http://www.lawyersforchildrenamerica.org/matriarch/documents/Issue_Brief_Social_Cap.pdf) [https://perma.cc/A7ZB-7E7J].

<sup>143</sup> See *infra* Section III.B.

<sup>144</sup> See *infra* Section III.B.

<sup>145</sup> See, e.g., ANNIE E. CASEY FOUND., THE KINSHIP DIVERSION DEBATE: POLICY AND PRACTICE IMPLICATIONS FOR CHILDREN, FAMILIES AND CHILD WELFARE AGENCIES 10 (2013), <http://www.aecf.org/m/pdf/KinshipDiversionDebate.pdf> [https://perma.cc/HV27-7TGK].

<sup>146</sup> *Id.* at 4.

<sup>147</sup> EMILY STOLTZFUS, CONG. RESEARCH SERV., CHILD WELFARE: THE FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT OF 2008, at 3 (2008).

<sup>148</sup> CHILD WELFARE INFO. GATEWAY, PLACEMENT OF CHILDREN WITH RELATIVES 2–5 (2013), <https://www.childwelfare.gov/pubPDFs/placement.pdf> [https://perma.cc/X652-FLYD].

<sup>149</sup> See *id.* at 22.

<sup>150</sup> See *id.* at 3.

*A. Proposed Methodology*

During the time of initial investigation, up to and including the first formal court hearing,<sup>151</sup> the focus is to maintain the child or youth at home with his or her family by the agency, another partner agency, or both.<sup>152</sup> Family engagement, relative search, and other family centered practices as outlined below should be incorporated. Involving healthy and safe family members and important connections may allow the child to either stay at home with safety plans in place or to stay temporarily with those others identified.

If after consideration of available means to prevent removal from family, the child or youth is legally removed from his or her parents, the focus of the work, practices, or efforts implemented during this next time period (between each crucial hearing) should be on returning the young person to family.<sup>153</sup> No longer would this period be a time to “wait and see”: (1) if the parent(s) complete(s) their case plan; (2) if any relatives will show up to help; or (3) if the child can maintain his or her placement.<sup>154</sup> During this time frame, the focus should be on the efforts required to maintain family connections and build a family support network that will always be there for the child. But what is needed to make this happen?

Once the child or youth is removed from their home, the child welfare process often takes on a life of its own. A variety of published flow charts used throughout the United States show a layout of the entire child welfare experience.<sup>155</sup> At the top of the chart is the child’s removal, followed by the hearings and possible outcomes during the case, until the bottom of the chart is reached where the child ages out of the system or the matter is dismissed by the court.<sup>156</sup> Many flow charts show just the hearings that will most likely be encountered during the court dependency experience<sup>157</sup> or when reasonable efforts findings are required.<sup>158</sup> The following is an example of

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<sup>151</sup> See BENCHCARD, *supra* note 57, at 6; ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 107.

<sup>152</sup> See BENCHCARD, *supra* note 57, at 12.

<sup>153</sup> See Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500, 503 (1980).

<sup>154</sup> *Id.* at 511.

<sup>155</sup> See, e.g., JUDICIAL BRANCH STATISTICAL INFO. SYS. MANUAL, JUVENILE DEPENDENCY FLOW CHART (Jan. 1, 2012), [http://www.courts.ca.gov/documents/Dependency\\_Flow\\_chart.pdf](http://www.courts.ca.gov/documents/Dependency_Flow_chart.pdf) [<https://perma.cc/4CHH-4F7E>].

<sup>156</sup> See *id.*

<sup>157</sup> See, e.g., TRIAL NOTEBOOK FOR CHILD WELFARE ATTORNEYS IN GEORGIA’S JUVENILE COURT DEPENDENCY CASES 25 (Mary Hermann & Karen Worthington eds., 2014), [http://abuse.publichealth.gsu.edu/files/2014/10/dependency\\_notebook\\_2014-3-31.pdf](http://abuse.publichealth.gsu.edu/files/2014/10/dependency_notebook_2014-3-31.pdf) [<https://perma.cc/ZG9N-EV75>].

<sup>158</sup> See *id.*

a chart that summarizes the hearings where reasonable efforts determinations are required to be made by the court.<sup>159</sup>

<b>STAGES IN THE CASE AT WHICH JUDICIAL REASONABLE EFFORTS DETERMINATIONS MUST BE MADE<sup>22</sup></b>		
<b>Removal/Shelter/ Detention Hearings</b>	<b>Review Hearings</b>	<b>Permanency Hearings</b>
<ul style="list-style-type: none"> <li>■ A finding that continuance in the home of the parent or legal guardian would be contrary to the child's welfare, (42 U.S.C. § 672(a)(1)), must be made at the time of the first court ruling authorizing the removal, even temporarily, of the child from the home. 45 C.F.R. § 1356.21(c)</li> <li>■ Placement and care are the responsibility of the State Agency. 42 U.S.C. § 672 (a)(2); 45 C.F.R. § 1356.71(d)(1)(iii)</li> <li>■ A judicial determination whether reasonable efforts were or were not undertaken to prevent a child's removal from the home must be made no later than 60 days from the date the child was removed. 45 C.F.R. § 1356.21(b)(i)</li> </ul>	<ul style="list-style-type: none"> <li>■ Judges must review the child's status and safety no less frequently than once every six months from the date that the child entered foster care, in order to determine:               <ul style="list-style-type: none"> <li>• whether the child's safety needs have been met and whether placement remains necessary and appropriate;</li> <li>• the extent of the agency compliance with the case plan in making reasonable efforts to return the child home safely or, if there is a court finding that reasonable efforts at reunification are not necessary, whether the agency has made reasonable efforts to complete steps necessary to finalize the permanency plan for the child; and</li> <li>• the likely date by which the child may be returned to and safely maintained in the home or placed for adoption, appointed a legal guardian, placed permanently with a relative, or placed in another planned permanent living arrangement. 42 U.S.C. 671(a)(15)(B),(C); 42 USC 675(5)(B); 45 CFR 1355.34 (c)(2)(ii); 45 CFR 1355.20.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ A permanency hearing must be held to select a permanent plan no later than 12 months from the date the child is considered to have entered foster care; and if the child remains in foster care, the state must obtain such a determination every 12 months thereafter. 45 C.F.R. § 1356.21(b)(2)(i); (42 U.S.C. § 675(5)(C) and (F); 45 C.F.R. § 1355.20)</li> <li>■ In those dependency cases where no reunification services are required or offered, the permanency hearing must be held within 30 days of the determination. 45 C.F.R. § 1356.21(h)(2)</li> <li>■ At the permanency hearing, the state must obtain a judicial determination that it made reasonable efforts to finalize the permanency plan that is in effect.</li> </ul>

A key aspect of the proposed methodology, and what is unique from the traditional flow chart approach, is the work that can be accomplished prior

<sup>159</sup> Fitzgerald et al., *supra* note 89, at 100.

to and in between each crucial hearing to bring the child or youth closer to being with family. So what are the promising or innovative services that can be incorporated and implemented to close the gaps in practice and increase the level of connection for the youth?

It has been established that the federal government has provided the essential legal mechanism(s) to include innovative practice areas as they develop or are incorporated in state statutes, policies, and programs.<sup>160</sup> Allowing the court to determine reasonable efforts on a case-by-case basis leaves room for these types of innovative practices to be utilized prior to the time of removal and at the same time as reunification services are being offered, in order to better ensure permanency for the child.

Viewing the time prior to the first hearing and the periods between subsequent hearings as opportunities to incorporate any aspects of the innovative practice models described below would begin a true focus on family involvement and movement toward permanency.<sup>161</sup> Further, by recognizing and utilizing the power of the reasonable efforts finding, the court can review what has been done pursuant to these innovative practice models and either find that reasonable efforts have or have not been met (i.e., cases where the practices were not utilized). Absent such an intentional approach that reinforces the urgency of attention and effort to children and families in crisis, we will continue to fall short in achieving permanency for large numbers of children.

### *B. Innovative Practice Areas*

Innovative child welfare practices have emerged that, when combined with an active and attentive judicial approach to enforce reasonable efforts standards, attend to the legislative intent in the federal child welfare statutes discussed above.<sup>162</sup> The following are notable child welfare practices, which should be implemented:

#### *1. Front End Practice Which Emphasizes Safety*<sup>163</sup>

A number of child welfare practices have emerged to improve the industry's ability to identify and mitigate harm and danger, and direct child welfare professionals to increase and improve their engagement with family (blood relatives and connections) to promote the child to safely remain

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<sup>160</sup> See *supra* Part II.

<sup>161</sup> See Appendix A.

<sup>162</sup> See *supra* note 105 and accompanying text.

<sup>163</sup> HEATHER MEITNER & MARGIE ALBERS, INTRODUCING SAFETY ORGANIZED PRACTICE 1 (2012), <http://bayareaacademy.org/wp-content/uploads/2013/05/SOP-Handout-Booklet-9-20-12.pdf> [<https://perma.cc/8WUL-XQ57>]; *About Action*, ACTION 4 CHILD PROTECTION, <http://action4cp.org/our-story/about-actio> [<https://perma.cc/V78C-YUBH>].

within the family.<sup>164</sup> These practices begin by amassing as many family connections as possible upon identification that children are or may be harmed in order to clarify the danger and determine if the “family” can mitigate the risk without the oversight of the court or the Department of Social Services.<sup>165</sup> These practices value family involvement and recognize that families know much more about the nature of and possible solutions to their problems, so that their voices are of critical importance (inclusive of children and youth).<sup>166</sup> They also value the entire experience of families and strive to learn what resources and strategies families use to prevent harm to children.<sup>167</sup> Key tools, questions, and techniques associated with these practices include: (1) three houses (good things, dreams, and worries); (2) safety circles; (3) harm and danger statements; (4) how many people can be in your living room in an hour?; and (5) getting to know people outside of their problems.<sup>168</sup>

## 2. *Family Finding*<sup>169</sup>

The goal of Family Finding is to create a robust asset base of support for every young person and family touched by the child welfare system, so that the asset base can be respectfully engaged, welcomed, and encouraged to participate in the support of the young person while developing and determining plans for the child’s future.<sup>170</sup> This outcome can be achieved for every child at risk of entering or in the process of entering the system, as well as for children languishing in foster care.<sup>171</sup> Key questions that guide the direction of tools, techniques, and strategies associated with Family Finding include: (1) Who can safely care for the child to avert entering care including a non-custodial parent?; (2) Who is related to or connected to this child and family on the planet?; (3) Who can safely be/stay involved and connected to this child and family?; (4) Who can come to the table and participate in planning and decision making to promote safety, permanency, and well-being?; and (5) Who will remain a part of the support network and how can they best contribute?

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<sup>164</sup> MEITNER & ALBERS, *supra* note 163, at 1.

<sup>165</sup> *See id.* at 4.

<sup>166</sup> *See id.* at 2, 4.

<sup>167</sup> *See id.* at 1–2.

<sup>168</sup> *Id.* at 5. *See also* Appendix A.

<sup>169</sup> *See More About Family Finding, supra* note 3.

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

### 3. *Dr. Darla Henry's 3-5-7 Model*<sup>172</sup>

The 3-5-7 Model was developed and created to work with children and young people in the foster care system to assure that they were ready for permanency.<sup>173</sup> The model has evolved into a core practice model for work with all families towards their readiness to parent in a committed relationship that assures permanency for the well-being of their children.<sup>174</sup> “The 3-5-7 Model incorporates 3 tasks, 5 conceptual questions and 7 interpersonal skill elements to support this work. The three (3) tasks of the model engage children, individuals and families, guiding practices that support their work of grieving and building relationships.”<sup>175</sup> The three tasks are: (1) clarification: to explore life events and form identity security; (2) integration: to make sense of all important relationships to establish the permanency of a relationship; and (3) actualization: to firmly recognize and feel secure within a permanent relationship.<sup>176</sup> The 3-5-7 Model is notable for its focus on:

- a. Providing fundamental instruction, practice, and guidance towards building healing relationships that explore losses through grief work with children, parents, extended and chosen family members.<sup>177</sup>
- b. Emphasizing 24/7 interaction and response to behaviors that are indicators of the pain being experienced from losses.<sup>178</sup>
- c. Identifying a framework to support grief and relationship-building work through the tasks of clarification, integration, and actualization towards readiness for decisions to be made for permanency in relationships.<sup>179</sup>
- d. Recognizing and supporting the advanced development of the skills (7) of all those who engage with families and young people in supporting their work.<sup>180</sup>

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<sup>172</sup> 3-5-7 *Model Overview*, DARLA L. HENRY & ASSOCIATES (2016), <http://darlahenry.org/overview> [<https://perma.cc/7C6J-FPNJ>].

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

<sup>175</sup> *Id.*

<sup>176</sup> *See id.*

<sup>177</sup> *Id.*

<sup>178</sup> *Id.*

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

#### 4. *Family Group Conferencing/Decision Making (FGDM)*

Family group decision making is a collaborative practice designed to mitigate the inherent power imbalance between large government institutions such as a child welfare agency, and the children, youth, and families they serve.<sup>181</sup> The establishment of a neutral facilitation process enhances the voice and participation of those served by separating the authority from the facilitation role, and allows more equal footing for all team members to brainstorm and develop plans to meet the safety, permanency and well-being needs of children and youth served.<sup>182</sup>

FGDM processes position the family group to lead decision making, and the statutory authorities agree to support family group plans that adequately address agency concerns. The statutory authorities also organize service providers from governmental and non-governmental agencies to access resources for implementing the plans. FGDM processes are not conflict-resolution approaches, therapeutic interventions or forums for ratifying professionally crafted decisions. Rather, FGDM processes actively seek the collaboration and leadership of family groups in crafting and implementing plans that support the safety, permanency and well-being of their children.<sup>183</sup>

Core elements of the FGDM process are:

- a. An independent (i.e., non-case carrying) coordinator is responsible for convening the family group meeting with agency personnel.<sup>184</sup>
- b. The child protection agency personnel recognize the family group as their key decision-making partner, and

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<sup>181</sup> AM. HUMANE ASS'N & THE FGDM GUIDELINES COMM., GUIDELINES FOR FAMILY GROUP DECISION MAKING IN CHILD WELFARE (2010), [http://www.ucdenver.edu/academics/colleges/medicalschoo/department/pediatrics/subs/can/FGDM/what\\_is\\_FGDM/Documents/FGDM%20Guidelines.pdf](http://www.ucdenver.edu/academics/colleges/medicalschoo/department/pediatrics/subs/can/FGDM/what_is_FGDM/Documents/FGDM%20Guidelines.pdf) [<https://perma.cc/RN7U-S9YA>].

<sup>182</sup> See *Family Group Decision Making in Child Welfare: Purpose, Values and Processes*, KEMPE CTR. FOR PREVENTION & TREATMENT CHILD ABUSE & NEGLECT (May 2013), <http://www.ucdenver.edu/academics/colleges/medicalschoo/department/pediatrics/subs/can/FGDM/Documents/FGDM%20Purpose%20Values%20and%20Processes.pdf> [<https://perma.cc/XG73-CN3B>].

<sup>183</sup> *Id.*

<sup>184</sup> *Id.*



- time and resources are available to convene this group.<sup>185</sup>
- c. Family groups have the opportunity to meet on their own, without the statutory authorities and other non-family members present, to work through the information they have been given and to formulate their responses and plans.<sup>186</sup>
  - d. When agency concerns are adequately addressed, preference is given to a family group's plan over any other possible plan.<sup>187</sup>
  - e. Follow-up processes after the family group decision making meeting occur until the intended outcomes are achieved, to ensure that the plan continues to be relevant, current and achievable, because family group decision making is not a one-time event but an ongoing, active process.<sup>188</sup>
  - f. Referring agencies support family groups by providing the services and resources necessary to implement the agreed-upon plans.<sup>189</sup>

#### 5. *Family Acceptance Project*<sup>190</sup>

The Family Acceptance Project works to prevent health and mental health risks for lesbian, gay, bisexual, and transgender (LGBT) children and youth, in the context of their cultures, families, and faith communities.<sup>191</sup> It utilizes a research-based, culturally grounded approach to help ethnically, socially, and religiously diverse families support their LGBT children.<sup>192</sup> The project was designed to:

- a) Study parents', families' and caregivers' reactions and adjustment to an adolescent's coming out and LGBT identity.
- b) Develop training and assessment materials for health, mental health, and school-based providers, child

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<sup>185</sup> *Id.*

<sup>186</sup> *Id.*

<sup>187</sup> *Id.*

<sup>188</sup> *Id.*

<sup>189</sup> *Id.*

<sup>190</sup> *Overview*, FAM. ACCEPTANCE PROJECT [hereinafter FAM. ACCEPTANCE], <https://familyproject.sfsu.edu/overview> [https://perma.cc/4VTL-EKZ4].

<sup>191</sup> *Welcome to the Family Acceptance Project*, FAM. ACCEPTANCE PROJECT, <https://familyproject.sfsu.edu> [https://perma.cc/RH7H-XJL3].

<sup>192</sup> *Id.*

welfare, juvenile justice, family service workers, clergy and religious leaders on working with LGBT children, youth and families.

- c) Develop resources to strengthen families to support LGBT children and adolescents.
- d) Develop a new model of family-related care to prevent health and mental health risks, keep families together and promote well-being for LGBT children and adolescents. Findings are being used to inform policy and practice and to change the way that systems of care address the needs of LGBT children and adolescents.<sup>193</sup>

Actions can be taken in accordance with each of these models to exponentially increase family involvement, address trauma, and improve the depth and quality of relationships. Utilization of the activities and strategies contained within these practice models will bring the child and youth closer to the establishment of safe and affirming relationships that improve well-being and maintain the family's connection to kin. Many of these activities and strategies can be levied prior to the family's involvement in the system to prevent unnecessary entries, or to reduce trauma if removal is required.<sup>194</sup> These strategies and activities can also be applied throughout the course of child welfare involvement to meet the legislative intent noted above. The actions or components outlined above, if implemented in a meaningful way, could and should be considered during court proceedings where a reasonable efforts finding is required. The attached checklist could be utilized by the court or any stakeholder to discuss activities that have been used.<sup>195</sup>

To date we have not taken the time and effort needed to ensure all information about family notification and involvement is before the judicial officer at each of the crucial hearings where reasonable efforts is required.<sup>196</sup> We can alter this trajectory by working to maintain the youth and family's existing support network early in the case, while continuing to build upon that support network throughout the life of the case and provide that information during these hearings. At every possible opportunity, we should ask: What can we be doing right now to ensure this child can safely remain with family?

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<sup>193</sup> FAM. ACCEPTANCE, *supra* note 190.

<sup>194</sup> *See id.*

<sup>195</sup> *See* Appendix A.

<sup>196</sup> *See* ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 109; EDWARDS, *supra* note 53, at 277.

*C. Preparing Ourselves*

Typically, the child welfare system's focus is on the parent's ability to reunify, which is the preferred permanent plan.<sup>197</sup> Meanwhile, the child is languishing in care.<sup>198</sup> As a result, there is often a failure to provide for children's short-term and long-term emotional needs when the state intervenes in the lives of their parents.<sup>199</sup> Because children are unable to maintain a sense of belonging, self-worth, and connectedness,<sup>200</sup> they leave care worse off than when they entered.<sup>201</sup>

When we recognize that some of the work we so passionately pursue is not moving a youth toward permanency, it is critical to take a brief pause or step back to refocus and align our time with the youth and family. First, every child welfare professional who works with the youth and family must understand what permanency truly is (i.e., a sense of belonging) and what it means to that particular youth and family. Because permanency is not a term that families typically use, the development of meaningful dialogue is essential to understanding the people and relationships that are important to this youth.<sup>202</sup> From a practice perspective, it is important to help facilitate a discussion in which the child and adults determine what they want and need to (1) promote reciprocal and sustainable relationships and (2) meet the child's needs for belonging and identity.

Second, child welfare professionals need to truly believe that permanency is possible for every child they serve.<sup>203</sup> Then, they must plan accordingly and relentlessly advocate for it. With every contact we have with the family and youth, we need to ask about "family."

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<sup>197</sup> See Adoptions and Safe Families Act of 1997, Pub. L. No. 105-89, § 101, 111 Stat. 2115, 2116 (1997).

<sup>198</sup> See AFCARS REPORT, *supra* note 85.

<sup>199</sup> See FROM PLACE TO PLACE (Porch Productions 2011); ANNIE E. CASEY FOUND., WHAT YOUNG PEOPLE NEED TO THRIVE: LEVERAGING THE STRENGTHENING FAMILIES ACT TO PROMOTE NORMALCY 2, 5 (2015), <http://www.aecf.org/m/resourcedoc/aecf-whatyoungpeopleneedtothrive-2015.pdf> [<https://perma.cc/G8CJ-BGAD>].

<sup>200</sup> MADELYN FREUNDLICH & JANA BOCKSTEIN, PERMANENT SOLUTIONS: SEEKING FAMILY STABILITY FOR YOUTH IN FOSTER CARE 110–11 (2008), [http://www.childrensrights.org/wp-content/uploads/2008/06/permanent\\_solutions\\_seeking\\_family\\_stability\\_for\\_youth\\_in\\_foster\\_care.pdf](http://www.childrensrights.org/wp-content/uploads/2008/06/permanent_solutions_seeking_family_stability_for_youth_in_foster_care.pdf) [<https://perma.cc/H4JG-PLFN>].

<sup>201</sup> See AGING OUT, *supra* note 119, at 5.

<sup>202</sup> Rosemary J. Avery, *An Examination of Theory and Promising Practice for Achieving Permanency for Teens Before the Age Out of Foster Care*, 32 CHILD. & YOUTH SERVICES REV. 399, 399 (2010).

<sup>203</sup> Rosemary J. Avery, *Identifying Obstacles to Adoption in New York State's Out-of-Home Care System*, 78 CHILD WELFARE LEAGUE AM. 653, 654–55 (1999).

Finally, we need to ensure that the necessary leadership is in place and committed to this plan of permanency.<sup>204</sup> Of special importance is judicial leadership, particularly at the most critical times in a child welfare case, such as the shelter-care hearing,<sup>205</sup> the six-month review hearing, and the permanency hearing.<sup>206</sup>

#### IV. STRATEGIES FOR SYSTEM STAKEHOLDERS

Start in your community by building a system collaborative.<sup>207</sup> All child welfare stakeholders, including the court, must work together to discuss how family members can be incorporated into the reasonable efforts findings and orders. Since these findings are made on a case-by-case basis, the collaborative could develop a systematic approach to which family engagement strategies and activities discussions would be the norm. This standard approach must be designed to enhance and embrace family involvement which will ensure that children do not enter the foster care system, unless it is a necessity.<sup>208</sup> When, as a last resort, a child or youth needs to come into care, the court must lead the way to ensure that the young person can live with an appropriate relative and/or important connection.<sup>209</sup> Each participant in the child welfare system should follow the recommended strategies.

##### A. Judicial Officer

In its role as gatekeeper, the court can intercede whenever a child is at risk of “foster care drift.”<sup>210</sup> By requiring a more thorough discussion with all stakeholders about how family is involved and requiring these actions for a favorable reasonable efforts determination, the judicial officer will be setting a clear path to permanency for all those who come to the attention of the child welfare system. Thus, the court can stop the flow of needless

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<sup>204</sup> SHIRLEY DOBBIN ET AL., BUILDING A BETTER COLLABORATION: FACILITATING CHANGE IN THE COURT AND CHILD WELFARE SYSTEM 11–12 (2004), <http://www.ncjfcj.org/sites/default/files/Building%20a%20Better%20Collaboration.pdf> [https://perma.cc/Z86D-S82M].

<sup>205</sup> BENCHCARD, *supra* note 57, at 6; ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 107.

<sup>206</sup> ENHANCED RESOURCE GUIDELINES, *supra* note 55, at 25.

<sup>207</sup> DOBBIN ET AL., *supra* note 204, at 12; Peter Watson, *Improving Child Welfare/Court Collaboration* 1–8 (2009), <http://muskie.usm.maine.edu/helpkids/rcpdfs/cwmatters9.pdf> [https://perma.cc/8UUC-2DGJ].

<sup>208</sup> Edwards, *supra* note 19, at 13–14.

<sup>209</sup> YOUTH TRANSITION FUNDERS GRP., CONNECTED BY 25: EFFECTIVE POLICY SOLUTIONS FOR VULNERABLE YOUTH 20 (2010), <http://www.ytfgconnectedby25.org/YTFGConnectedby25FullIssueBriefApril2010.pdf> [https://perma.cc/LG48-X2CK].

<sup>210</sup> J. Leonard P. Edwards, *The Juvenile Court and the Role of the Juvenile Court Judge*, 43 JUV. & FAM. CT. J. 1, 28 (1992).

removals and placements that perpetuate situations where children and youth are unlikely to ever achieve permanency.<sup>211</sup> For the child welfare system to truly meet the needs of vulnerable children and their families, judicial determinations from the onset must be as thoughtful, evidence-informed, and permanency-focused.

### *B. Attorney for Child/Youth*

The attorney for the child has an additional duty to seek out information and conduct an independent investigation of potential family supports.<sup>212</sup> It is incumbent upon the attorney to discuss with the child who is important to him or her, whether kin, family friends, or other involved individuals in the community.<sup>213</sup> This can be accomplished through probative type questioning.<sup>214</sup> Identifying relatives, important connections, and people who the child trusts is critical not only for keeping the child connected in the early stages of the child welfare intervention process, but for helping the child to build/maintain a lifelong network of supports.

### *C. Attorney for Parent*

The attorney for either the mother, father, or child's guardian also has the opportunity to discuss with his or her client about how large their family might be. Rather than asking the parent who would be able to take their child for placement, the attorney can find out who the parent trusts or looks to for support to generate a list of important connections to support the parent throughout their involvement with the child welfare system and beyond. This information can be especially crucial if the parent is seeking reunification.

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<sup>211</sup> NAT'L COUNCIL OF JUVENILE & FAMILY COURT JUDGES, KEY PRINCIPLES FOR PERMANENCY PLANNING FOR CHILDREN 1 (2011), [http://www.ncjfcj.org/sites/default/files/keyprinciples.final\\_permplanning.pdf](http://www.ncjfcj.org/sites/default/files/keyprinciples.final_permplanning.pdf) [https://perma.cc/E7QG-CJU7].

<sup>212</sup> JENNIFER L. RENNE, LEGAL ETHICS IN CHILD WELFARE CASES 7 (2004), [http://www.americanbar.org/content/dam/aba/administrative/child\\_law/2004\\_LegalEthics.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/child_law/2004_LegalEthics.authcheckdam.pdf) [https://perma.cc/K779-9ZZS].

<sup>213</sup> BRITT WILKENFELD ET AL., NEIGHBORHOOD SUPPORT AND CHILDREN'S CONNECTEDNESS (Feb. 2008), [http://www.childtrends.org/wp-content/uploads/2013/03/Child\\_Trends-2008\\_02\\_05\\_ConnectednessFS.pdf](http://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends-2008_02_05_ConnectednessFS.pdf) [https://perma.cc/6GFA-U596].

<sup>214</sup> ABA STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES 12–13 (Feb. 5, 1996), [http://www.americanbar.org/content/dam/aba/migrated/family/reports/standards\\_abuseneglect.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/migrated/family/reports/standards_abuseneglect.authcheckdam.pdf) [https://perma.cc/9S68-QA7G]; see Robert G. Lewis & Communities for People, *The Family Bound Program: A Toolkit for Preparing Teens for Permanent Family Connections*, <http://rglewis.com/Family%20Bound%20Program%20Description.pdf> [https://perma.cc/33H9-BKER].

*D. Court Appointed Special Advocate (CASA)*

The CASA can continuously advocate for and support connectedness and permanency for the child in a variety of ways. These may include: (1) helping to support contact with siblings and extended family; (2) promoting curiosity about and enhancing discovery of family members by asking who else has loved or cared for the child; (3) holding hope for the child to thrive and succeed; (4) acting as a convener to help build an unconditionally committed permanency team; and (5) helping to ensure that the child's needs are identified and at the center of all planning and interventions.<sup>215</sup> The CASA should always be asking: What are we doing to address the child's need and desire to belong?

*E. Child Welfare Worker*

For child welfare workers, meeting the intent of federal legislation requires a recognition that safety and well-being cannot exist without permanency.<sup>216</sup> From a practice perspective, this means adopting a laser-like focus on establishing and embracing an asset base of support for young people and their parents as a primary intervention from their first involvement with the child welfare system. When government intervention is determined to be necessary, the worker can strategize with known family and connections to minimize trauma and disconnection from parents and loved ones. By recognizing that placement is a system-driven need rather than an individual need for young people, the child welfare worker can emphasize the establishment of enduring natural support networks to promote permanency for children and youth, rather than relying upon a smaller and less committed pool of placement options. Workers must embrace the belief that families can solve their problems and that permanency is possible for every young person.<sup>217</sup> By respecting and treating family members as experts in their own matters, the child welfare worker will create ample opportunity for kin to participate safely in the lives of children at risk of profound and debilitating loneliness. Since the quality of relationships is critical to the success of permanency planning efforts, workers must increase their time spent on getting to know people outside of their problems. By shifting from a role that decides the fate of young people in care to one that encourages and nourishes natural support networks to

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<sup>215</sup> *What Does It Mean to be a CASA Volunteer?*, CT. APPOINTED SPECIAL ADVOC. (2017), [http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.6350721/k.112A/What\\_Does\\_It\\_Mean\\_To\\_Be\\_a\\_CASA\\_Volunteer.htm](http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.6350721/k.112A/What_Does_It_Mean_To_Be_a_CASA_Volunteer.htm) [<https://perma.cc/AP2D-6XFG>].

<sup>216</sup> See Avery, *supra* note 202, at 399.

<sup>217</sup> See *id.* at 402.

solve family challenges, the child welfare worker and their agencies will manifest the honor and respect that families deserve.

#### V. CONCLUSION

The reasonable efforts requirement has been in effect for over thirty-five years in child welfare law; however, it continues to be underutilized, misinterpreted, and in many cases, ignored.<sup>218</sup> To fulfill the intent of this vital federal legislation, the courts, child welfare agencies, and other stakeholders should embrace and implement a clear approach that incorporates family-centered, evidence-informed practices designed to support children to remain safely at home, return to family, or remain with family and kin at the earliest point possible.

While there may indeed be children and youth who require the state to assume the role of parent because there is no other alternative, most young people have relatives, family friends, neighbors, and important connections that are underutilized or ignored in the prevention of removal and the permanency planning process. If system professionals are able to identify and reach out to these adults early and often, not only will they have met the reasonable efforts requirements, but they will have helped to build lifelong family support networks that enable young people to thrive during and well beyond childhood.<sup>219</sup>

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<sup>218</sup> Blome, *supra* note 1, at 141; Shotton, *supra* note 19, at 223–26; EDWARDS, *supra* note 53, at 23; RATTERMAN ET AL., *supra* note 32, at 13.

<sup>219</sup> YOUTH TRANSITION FUNDERS GRP., *supra* note 209, at 20.

**APPENDIX A**

Name of Program	X	Highlighted Components
<b>Signs of Safety/Safety Organized Practice</b>	<input type="checkbox"/>	Three Houses (good things, dreams, worries)
	<input type="checkbox"/>	Safety Circles
	<input type="checkbox"/>	Harm and Danger Statements
	<input type="checkbox"/>	How many people can be in your living room in an hour?
	<input type="checkbox"/>	Getting to know people outside of their problems
<b>Family Finding</b>	<input type="checkbox"/>	Who can safely care for the child to avert entering care including non-custodial parent?
	<input type="checkbox"/>	Who is related to or connected to this child and family on the planet?
	<input type="checkbox"/>	Who can safely be/stay involved and connected to this child and family?
	<input type="checkbox"/>	Who can come to the table and participate in planning and decision making to promote safety, permanency and well-being?
	<input type="checkbox"/>	Who will remain a part of the support network and how can they best contribute?
<b>Dr. Darla Henry's 3-5-7 Model and Program</b>	<input type="checkbox"/>	Providing fundamental instruction, practice, and guidance towards building healing relationships that explore losses through grief work with children, parents, extended and chosen family members
	<input type="checkbox"/>	Emphasizing 24/7 interaction and response to behaviors that are indicators of the pain being experienced from losses
	<input type="checkbox"/>	Identifying a framework to support grief and relationship-building work through the tasks of clarification, integration, and actualization towards readiness for decisions to be made for permanency in relationships



	<input type="checkbox"/>	Recognizing and supporting the advanced development of the skills (7) of all those who engage with families and young people in supporting their work
<b>Family Group Counseling/Decision Making</b>	<input type="checkbox"/>	An independent (i.e., non-case carrying) coordinator is responsible for convening the family group meeting with agency personnel
	<input type="checkbox"/>	The child protection agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group
	<input type="checkbox"/>	Family groups have the opportunity to meet on their own, without the statutory authorities and other non-family members present, to work through the information they have been given and to formulate their responses and plans
	<input type="checkbox"/>	When agency concerns are adequately addressed, preference is given to a family group's plan over any other possible plan
	<input type="checkbox"/>	Follow-up processes after the family group decision making meeting occur until the intended outcomes are achieved, to ensure that the plan continues to be relevant, current and achievable, because family group decision making is not a one-time event but an ongoing, active process
	<input type="checkbox"/>	Referring agencies support family groups by providing the services and resources necessary to implement the agreed-upon plans
<b>Family Acceptance Project</b>	<input type="checkbox"/>	Study parents', families' and caregivers' reactions and adjustment to an adolescent's coming out and LGBT identity
	<input type="checkbox"/>	Develop training and assessment materials for health, mental health, and school-based providers, child welfare, juvenile justice, family service workers,

		clergy and religious leaders on working with LGBT children, youth and families
	<input type="checkbox"/>	Develop resources to strengthen families to support LGBT children and adolescents
	<input type="checkbox"/>	Develop a new model of family-related care to prevent health and mental health risks, keep families together and promote well-being for LGBT children and adolescents. Findings are being used to inform policy and practice and to change the way that systems of care address the needs of LGBT children and adolescents







CDSS

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**DEPARTMENT OF SOCIAL SERVICES**

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EDMUND G. BROWN JR.  
GOVERNOR

March 13, 2018

ALL COUNTY INFORMATION NOTICE (ACIN) No. I-14-18

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

TO: ALL COUNTY CHILD WELFARE PROGRAM MANAGERS  
 ALL COUNTY WELFARE DIRECTORS  
 ALL CHIEF PROBATION OFFICERS  
 ALL TITLE IV-E AGREEMENT TRIBES  
 ALL ADOPTION REGIONAL AND FIELD OFFICES  
 ALL FOSTER FAMILY AGENCIES  
 ALL GROUP HOME DIRECTORS  
 ALL SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAM DIRECTORS  
 ALL INDEPENDENT LIVING PROGRAM COORDINATORS  
 ALL BEHAVIORAL HEALTH DIRECTORS

SUBJECT: DISSEMINATION AND USE OF THE “WHAT IS A CHILD AND FAMILY TEAM (CFT)?” BROCHURES DESIGNED FOR YOUTH, PARENTS, AND PROFESSIONALS

REFERENCE: [ALL COUNTY LETTER \(ACL\) NO. 16-84/MENTAL HEALTH SUBSTANCE USE DISORDER SERVICES INFORMATION NOTICE NO. 16-049;](#)  
[WELFARE AND INSTITUTIONS CODE \(WIC\), SECTION 706.6;](#)  
[WIC SECTION 832; WIC SECTION 16501;](#)  
[PATHWAYS TO MENTAL HEALTH SERVICES – CORE PRACTICE MODEL GUIDE; ACL NO. 18-09/MHSUDS IN 18-007](#)

The purpose of this ACIN is to provide counties and their partners with information about the available Child and Family Team (CFT) brochures designed as a resource for use in providing outreach and support about the CFT process, guidelines, and frequently asked questions for children, youth, nonminor dependents, parents, and professionals. The CFT brochures are posted on the California Department of Social Services’s (CDSS’s) [Continuum of Care Reform](#) (CCR) web site, and provide an

overview of the CFT process, the composition of CFTs and team roles, team meetings, frequently asked questions, and other helpful information for CFT participants.

## **Background**

The CCR made sweeping changes to California's child welfare system, one of which is the fundamental principle that child welfare services, and the necessary supports for success, are most effective when delivered in the context of an authentic engagement between the child, youth, or nonminor dependent, the family, and the professionals responsible for supporting them. The primary communication and engagement process involves the use of CFT meetings, where the shared responsibility to assess, plan, intervene, monitor, and refine services over time occurs.

Implementation of the CCR requires that Child Welfare and/or Probation Departments must convene or provide a CFT meeting to all children, youth, and nonminor dependents who enter foster care on and after January 1, 2017. This requirement also applies to children, youth, and nonminor dependents already in a foster care placement prior to January 1, 2017. Therefore, all children, youth, and nonminor dependents are required to have a CFT according to the requirements outlined in [ACL 16-84](#).

The requirement to provide CFTs builds upon existing family-centered and team-based approaches already in use across California. In further support of the ongoing efforts of CCR and Pathways to Well-Being, the use of a strengths-based, family-centered CFT process is key to engaging children, youth, nonminor dependents, and families in the development of case plans or treatment plans designed to meet their needs. This focus on engagement is also reflected in CDSS's recent selection of the Child and Adolescent Needs and Strengths (CANS) assessment as the functional assessment tool that child welfare agencies will be using within the CFT process.<sup>1</sup> Research is clear that by sharing decision-making and working together, professionals, children, youth, and nonminor dependents, and families can achieve positive and lasting outcomes.

Aligning with CFT requirements and specific to the needs of each group, three different brochures were developed within CDSS to inform youth, parents, and involved professionals about the CFT process.

The CDSS worked closely with youth partners at the Youth Engagement Project and California Youth Connection, Parent Partners, and other internal and external stakeholders in the design of these brochures.

## **The Child and Family Team Brochures**

Each brochure's front panel is labeled Child and Family Team (CFT) and sub-classified respectively as **Youth Brochure**, **Parent(s) Brochure**, or **Professionals Brochure**.

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<sup>1</sup> [ACL NO. 18-09/MHSUDS IN 18-007](#)

The brochures align with CFT requirements and guidelines and provide guidance specific to the needs of each group.

The inside section of the CFT brochure, page one, includes the definition of a CFT, “What is a Child and Family Team?”, a list of frequently asked questions, and a resource reference to the CCR web site to obtain additional information. The reverse side of the brochure, page two, contains Team member attendance information “Who attends the meetings?”

Additionally, on the back of the brochures, participants are encouraged to write contact information for other Team members and providers. There is also a Quick Response barcode through which the brochure’s information can be readily accessed online via a smartphone.

**Obtaining a Copy of the Brochures:**

The CFT brochures are available as PDF, Americans with Disabilities Act-compliant documents for download and printing on CDSS’s CCR website via this link: [Continuum of Care Reform website](#).

When printing the brochure from the link, it will display best when printed using legal-sized, 8.5”x14” paper.

Once printed, fold paper in half with the family group picture and title in the front. Fold in half again, so the brochure is now in fourths and ready to distribute.

For additional information regarding CFTs, please contact the Integrated Services Unit at (916) 651-6600, or by e-mail at [CWSCoordination@dss.ca.gov](mailto:CWSCoordination@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

MARY SHEPPARD, LCSW, Chief  
Child Protection and Family Support Branch  
Children and Family Services Division

Attachments

c: California Alliance of Child and Family Services  
County Welfare Directors Association  
Chief Probation Officers of California  
Judicial Council of California

## Who attends the meetings?

The CFT composition always includes the child or youth/nonminor dependents, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important.

### Required:

- Child or Youth/Nonminor Dependents
- Family Members
- Current Caregiver(s)/Resource Parent(s)
- Skilled and Trained CFT Facilitator
- Child Welfare Social Worker and/or Deputy Probation Officer

### Required as Applicable:

- Behavioral Health Staff
- Community Service Providers
- FFA Social Worker or STRTP Representative
- Regional Center Staff
- School Staff
- Child or Youth's Educational Rights Holder
- Tribe or Indian Custodian

### Suggested Team Members:

- Friends/Neighbors
- Youth Partners
- Parent Partners
- Faith Based/Spiritual Supports
- Court Appointed Special Advocates (CASAs)
- Coaches
- Daycare Providers
- Community Members
- Other Natural Supports

## The CFT

- Honoring the voice, choice, and preferences of the child or youth/nonminor dependent and family are integral to the success of the CFT.
- Professionals should consider the family's ideas before making their own suggestions. The CFT process is predicated upon the premise that the child or youth/nonminor dependent and family are experts of their own lives and should be heard.
- CFT meetings will be documented and are a driver of trauma-informed case plan development.



## Team Members

OUR TEAM MEMBERS	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	

OUR NEXT MEETING	
Date	
Time	
Location	

## Child and Family Team (CFT)





## What is a Child & Family Team?

Child or youth/nonminor dependents, family members, trusted adults, and caring professionals who work together in achieving goals for positive change and improving child safety, permanency, and well-being.

### Child and Family Teams seek to:

- Recognize children and youth/nonminor dependents and families as the experts in their lives
- Develop plans to meet child or youth/nonminor dependent's and family's goals
- Value and respect the child or youth/nonminor dependent's and family's culture
- Foster independence and begin transition planning from the beginning of care
- Plan and coordinate to ensure there is only one process for the child or youth/nonminor dependent and family
- Ensure the plan of action and services are aligned among service providers

### How often do meetings occur?

Effective practice dictates that meetings should be held as frequently as needed to address emerging issues, provide integrated and coordinated interventions, and refine the plan as needed.

The frequency of meetings should be decided by CFT members and based on, or dictated by, the family's needs. At a minimum, the

law requires a meeting at least once every six months.

Professionals should rely on the CFT for development and decisions made regarding the case plan.

For children or youth/nonminor dependents who are receiving specialty mental health services such as Intensive Care Coordination (ICC) or Intensive Home-Based Services (IHBS) or Therapeutic Foster Care (TFC):

CFT meeting must occur at least once every 90 days.

### Where do meetings occur?

CFT meetings are held in a location and time which are most convenient for the family.

Family homes are the preferred location, but meetings can take place elsewhere, including agency meeting rooms, religious organizations, conference centers,

community based centers, or foster family agency sites.

If a CFT member cannot be physically present, alternatives such as conferencing should be considered.



## Professional staff at meetings seek to:

- Honor family's unique culture by including familiar language and ideas in the case plan
- Establish "ground rules" to make sure there is safe, honest, and confidential communication within the CFT process
  - » Use trauma-informed approaches when talking with children, youth/nonminor dependents and family members so they feel heard and not judged
- A trained and skilled facilitator will define a clear purpose for the Team through a vision statement which will guide planning and be upheld by all Team members
- Work to build relationships that support the development of trust
  - » Encourage hope by conveying belief that each family member can achieve success
- Support and facilitate the family's capacity to advocate for themselves
  - » Child or youth/nonminor dependents and family voice and choice are central to the CFT process
- Explain the CFT process to the CFT members and have an agenda prior to CFT meetings
  - » From the beginning and throughout the process, engage with families in formal and informal safety and risk assessments and permanency planning
- Cross-system planning and coordination will ensure that there is only one team process for a family, making access to care easier and quicker for the child or youth/nonminor dependent



## What is a Child & Family Team?

Child or young adult, family members, trusted adults, and caring professionals who work together in achieving goals for positive change and improving child safety, permanency, and well-being.

### Child and Family Teams

- Your strengths and your family's strengths are the focus in finding solutions
- Your family culture is respected
- You and your family are recognized as the experts in your lives
- Your voice and choice, as well as your family's, are central to the CFT process
- Develop plans to meet your goals and your family's goals



## What should I expect at a meeting?

- A strengths-based approach to find out how to help your family
- Your Team establishes "ground rules" to make sure there is safe, honest, and confidential communication within the CFT process
  - » A facilitator will lead the group discussion
  - » Certain members may take confidential notes
- Your Team has a clearly stated goal for every meeting
- Your Team brainstorms options and action steps, with all Team members (which includes you) having a voice
- All Team members agree to complete specific tasks and responsibilities

For more information visit:

<http://www.cdss.ca.gov/inforesources/Continuum-of-Care-Reform>

## Questions I may have:

### How is a CFT meeting scheduled?

Your child or young adult and your family are the most important members of a CFT!

All CFT members make a commitment to attend meetings. Meeting times and locations are scheduled so that they are convenient for you and your family. Your Team will also work with you to communicate meeting information most conveniently: with a phone call, a text, or an email.

### Will I need to pay for this?

No. All children and young adults in foster care and juvenile probation will be provided a CFT at no cost.

### Who can come to the meetings?

Parents, caregivers, friends, and other people you identify as important may attend.

The child welfare social worker or deputy probation officer may need to obtain court approval for parents who have had parental rights terminated before inviting them to attend CFT meetings.

### When will the CFT service end?

The CFT will be an active part of your child or young adult's plan as long as he/she is in the child welfare system and/or the juvenile probation system.

### How often does the CFT meet?

You, your child or young adult, and the Team will decide how frequently the group will meet depending on your child or young adult's needs and the needs of your family.

### How will I know what services are available for me as a parent?

Your Team will work with you to identify each family member's strengths and needs to develop a case plan that is centered around your child or young adult and family. The case plan has specific strategies for achieving your child or young adult's and/or family's goals based on identified needs.

A Team member, such as the social worker, deputy probation officer, and CFT facilitator will help coordinate services that are needed.

### What happens if I am not getting along with members of my Team or if I feel uncomfortable with a Team Member?

CFT meetings are facilitated by professionals trained and skilled in dealing with different situations that might arise.

The Team will work with you and everyone involved to resolve issues.

## Who attends the meetings?

The CFT composition always includes the child or young adult, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important.

### Required:

- Your Child or Young Adult
- Your Family Members
- Your Child or Young Adult's Current Caregiver(s)/Resource Parent(s)
- Your CFT Facilitator
- Your Child or Young Adult's Social Worker and/or Deputy Probation Officer

### Required as Applicable:

- Behavioral Health Staff
- Community Service Providers
- FFA Social Worker or STRTP Representative
- Regional Center Staff
- School Staff
- Child or Young Adult's Educational Rights Holder
- Tribe or Indian Custodian

### Suggested Team Members:

- Your Friends/Neighbors
- Your Child or Young Adult's Youth Partners
- Your Parent Partners
- Your Faith Based/Spiritual Supports
- Your Child or Young Adult's Court Appointed Special Advocates (CASAs)
- Your Child or Young Adult's Coaches
- Your Child's Daycare Providers
- Your Community Members
- Your Other Natural Supports

## What is my role as a member?

- Your family is at the center of this process and the most important part of the team.
- Attending every meeting is part of the plan so the Team can hear from you and your child or young adult directly.
- The Team needs and wants to hear what you say! Share your opinions, thoughts, and concerns.

Who do you count on as a support person? A friend? A neighbor? Invite them to be part of the Team, too!



## Team Members

OUR TEAM MEMBERS	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	

OUR NEXT MEETING	
Date	
Time	
Location	

## Child and Family Team (CFT)



Parent(s)



## Who attends the meetings?

The CFT composition always includes you, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important.

### Required:

- You
- Your Family Members
- Your Current Caregiver(s)/Resource Parent(s)
- Your CFT Facilitator
- Your Social Worker and/or your Deputy Probation Officer

### Required as Applicable:

- Behavioral Health Staff
- Community Service Providers
- FFA Social Worker or STRTP Representative
- Regional Center Staff
- School Staff
- Your Educational Rights Holder
- Tribe or Indian Custodian

### Suggested Team Members:

- Friends/Neighbors
- Youth Partners
- Parent Partners
- Faith Based/Spiritual Supports
- Court Appointed Special Advocates (CASAs)
- Coaches
- Daycare Providers
- Community Members
- Other Natural Supports

Who do you count on as a support person? A friend? A neighbor? Invite them to be part of the Team, too!

## What is my role as a member?

- You are an important member of a Team who comes together to help you and your family.
- The Team needs and wants to hear what you say! Speak up and share your opinions, thoughts, and concerns.
- You and your family are at the center of this process. Attending every meeting is part of the plan so the Team can hear from you directly.



## Team Members

OUR TEAM MEMBERS	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	
Name	
Phone	

OUR NEXT MEETING	
Date	
Time	
Location	

## Child and Family Team (CFT)



Youth



## What is a Child & Family Team?

You, family members, trusted adults, and caring professionals who work together in achieving goals for positive change and improving child safety, permanency, and well-being.

### Child and Family Teams

- Your strengths and your family's strengths are the focus in finding solutions
- Your family culture is respected
- You and your family are recognized as the experts in your lives
- Your voice and choice, as well as your family's, are central to the CFT process
- Develop plans to meet your goals and your family's goals

### Questions I may have:

#### Am I able to share information from the CFT with my attorney?

Yes, you are able to share information about the CFT with your attorney. The Team is there to help you and your family.

#### What happens if my Resource Parent(s) and Parent(s) are not getting along?

The Team will work with you and your family to develop a plan to address this and move towards achieving the plan goals.

#### How is a CFT meeting scheduled?

You are the most important member of a CFT! All CFT members make a commitment to attend meetings. Meeting times and locations are scheduled so that they are convenient for you and your family.



#### Can I see my case plan?

Yes. Information sharing is an important part of the CFT, so talk with your social worker or deputy probation officer about wanting to see your case plan.

#### What if my parents' rights have been terminated? Can they still come to the meetings?

In some cases, biological parents may be able to attend CFT meetings. Check with your Team, since your social worker or deputy probation officer may need to go to Court for approval.

#### What happens if I am not getting along with members of my Team?

Make sure you tell a trusted Team member so you can all work together to develop a plan to address this and move towards achieving the plan goals.

#### Can I ask for a CFT meeting if I'm worried about a circumstance in my life?

Yes. A CFT meeting may be requested by you to address issues and brainstorm options for action steps. Your Team will work together to help you and your family with your needs.

Some reasons why a CFT meeting is requested include:

- You have concerns about your placement
- You are not able to attend regular sibling or family visits because of distance, transportation, or supervision
- You are not able to participate in after-school activities, such as sports or school functions
- You are missing your Independent Living Program (ILP) classes
- Your needs have changed

## What should I expect at a meeting?

- Your Team establishes "ground rules" to make sure there is safe, honest, and confidential communication within the CFT process
  - » A facilitator will lead the group discussion
- Your Team has a clearly stated goal for every meeting
- All Team members have a voice
- Your Team brainstorms options and decides on specific actions steps
- All Team members agree to complete specific tasks and responsibilities



#### Can I have my CASA/Guidance Counselor/ Youth Partner/Spiritual Advisor go to a CFT meeting?

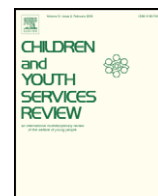
Yes! You are encouraged to request that the people in your life who are important to you and willing to support your goals be invited to participate in the CFT.

#### How will I know what services are available in my county?

Your Team will work with you to assess your needs and explain what services are available in your county. A Team member, such as your social worker, deputy probation officer, and CFT facilitator will help coordinate services that are needed.

#### If I feel uncomfortable with any part of the process, what can I do?

If you feel worried or upset about any part of the process, you can communicate directly with one or more of your Team members.



## An examination of theory and promising practice for achieving permanency for teens before they age out of foster care

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### ABSTRACT

In this paper research is presented that examines the efficacy of Independent Living (IL) services in preparing foster youth to live “independently”, and calls into question the appropriateness of an “independence” goal for youth aging out of foster care. The paper then reviews the emerging conceptualization of youth permanency in child welfare practice that focuses on lifelong connections to kin and fictive kin as requirements for permanency. The paper then reports on the success of a federally-funded demonstration project that served youth in residential treatment facilities and group homes in New York City aging out of care. It examines elements of the project model that were highly successful in achieving family-based permanency for a significant proportion of youth referred to the program and concludes that it is a promising practice model for the profession.

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### 1. Introduction

The majority of youth who age out of foster care face enormous challenges. Many leave care disconnected from supportive adults, services, and socioeconomic supports that would significantly increase their chances of becoming productive, self-sustaining adults (Metzger, 2006). Research indicates that youth who age out of foster care to “independent living” are more likely to experience homelessness, unemployment, unplanned pregnancy, legal system involvement, substance abuse, and lack even the basic health care services. They also are less likely to have a high school diploma, earn enough to support themselves, or participate in post-secondary education or training (Courtney, Dworsky, Ruth, Havlick & Bost, 2005). Foster care support, which provides housing, financial support, and a range of health, education and other needed services, typically ends when youth are developmentally unprepared to assume full adult roles and responsibilities. Furthermore, Independent Living (IL) programs have proven inadequate to prepare youth for “independence” in any meaningful way. Too many youth leave care unconnected to committed adults in their lives who could buffer the challenges they face and serve as safe havens in times of need.

Increasing policy, program, and practice attention are being devoted to developing new strategies to enhance the capacities of youth emancipating from foster care to achieve better outcomes. The Adoption and Safe Families Act of 1997 and, most recently, the Fostering Connections to Success and Increasing Adoptions Act of

2008 have strengthened the mandate that each youth leave foster care with a permanent family through safe reunification with their parents, adoption, guardianship, or that they have “another planned permanent living arrangement” (Center for the Study of Law and Social Policy, 2008). The Fostering Connections to Success and Increasing Adoptions Act of 2008 provides several tools for prioritizing family connections. The bill gives states the option of extending financial supports to kin providers and older youth. It includes new mandates for notifying kin, analyzing the use of kin foster care, and explaining foster care benefits and requirements to kin (Kerman & Glasheen, 2009).

Until recently, however, the issue of permanence for youth has lacked sufficient attention in the child welfare community and misconceptions about the issue abound, including that people do not want to adopt teens, teens do not want to be adopted, and that placements of teens are unsuccessful (Louisell, 2009). Furthermore, despite the rapidly burgeoning research literature on youth leaving care, there has been surprisingly little attention paid to the reconnection of former foster youth with birth families and other kin in the post care period. The empirical findings are scattered and often hidden in studies examining outcomes for former foster youth and the evaluation of IL programs (Collins, Paris, & Ward, 2008). Moreover, there has been little or no attention paid to well-established theories of child development that shed serious doubt on the assumption of age 18 as the appropriate life-marker transition age for “adulthood” and launching foster youth into independence.

There is an abundance of research indicating that successful youth development is inextricably linked to relationships with the family of origin and other fictive kin that influence developmental trajectories and life changes in adulthood (Arnett & Tanner, 2006; Cooney & Kurz,

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1996). Adolescents on the path to adulthood rely upon their families for myriad forms of support, support that is critically important to their development and future life outcomes. Reestablishing these family connection for teens before they exit out of foster care, no matter what age they are, is the strongest and most positive youth development program the child welfare system can offer, and it is imperative that child welfare professionals identify 'promising practice' service models that are effective at achieving this outcome for teens if the goals of the Fostering Connections to Success and Increasing Adoptions Act of 2008 are to be met.

In this paper research from developmental and socio-psychology on the transition into adulthood for the general U.S. population is examined. This research will indicate that the transition to adulthood is a gradual process for most adolescents, unrelated to a specific nominal age, and that true "adult" functioning in terms of cognitive, behavioral, and social maturity is not achieved for the majority of emerging adults until the third decade of life. Next research is examined from the child development literature on the critical role of social capital (parents, kin, social supports) in guiding and supporting youth during this transition to adulthood and the deleterious consequences for them when this support is absent. Then, turning the attention to the child welfare system, research is presented that examines the efficacy and adequacy of IL services in preparing youth to live "independently", and calls into question the appropriateness of an "independence" goal for any youth in care. The paper then reviews a new conceptualization of youth permanency that appears to be gaining greater currency within the profession, one that is reframing the concept of "permanency" for youth in care in terms of lifelong connections to kin and fictive kin. But, while this new philosophy is emerging, the paper notes that effective practice models for finding permanent parents for teens before they age out of care still lag behind changing conceptualizations. The Children's Bureau (Department of Health and Human Services (DHHS)) views the development of these effective service models as critical to practice change within the profession and has made it a priority funding area for demonstration projects. This paper reports on the success of one such federally-funded demonstration project that serviced youth in residential treatment facilities and group homes in New York City. It examines elements of the project model that were highly successful in achieving family-based permanency for a significant proportion of youth referred to the program and concludes that it is a "promising practice" model for the profession.

## 2. Emerging adulthood and home leaving

During the latter half of the 20th century and into the first decade of the 21st century, the transition to adulthood for U.S. teens has become longer, more complex, uncertain, and diverse (Arnett, 2007). The median age for completing school, marrying, and becoming a parent has steadily risen, and young adults well into their 20s continue to juggle work and school, live at home longer, and delay marriage and their own nuclear family formation. Although the median age at which adolescents first leave home is about 19 years, 40% of those who leave home for the first time between the ages of 18 and 24 return to live in their parental household at some time thereafter, although usually for only a temporary period. About 25% of children do not leave home for the first time until age 22 or later (Aquilino, 1996). Furthermore, the economic demands for, and returns to, education have increased relentlessly during the past four decades. In response, young people have delayed the assumption of adult roles until their education has been completed, and the data indicate a shrinking fraction of young people entering full-time work before their early twenties, and a growing number doing so only toward the end of their twenties (Furstenberg, Rumbaut, & Settersten, 2005).

Arnett (2007) conceptualizes the transition from adolescence into adulthood as "emerging adulthood". He describes the period from (roughly) 18 to 25 as a period in the life course with certain common features, different in important ways from adolescence that precedes it and young adulthood that follows it. He describes this period as one in which progress toward independence is made rather than achieved. Arnett and Taber (1994) identify three developmental domains in which these transitions to adulthood take place: the cognitive domain, which is characterized by the development of adult reasoning that includes not only logical reasoning but also subjective feelings and personal experiences, a sense of responsibility to others, and interdependence within a larger society; the emotional domain, which is characterized by the development of autonomy from one's parents (not complete separation but mutuality and reciprocity as equal adults) and the ability to establish intimacy in adult relationships; and the behavioral domain, which is characterized by the establishment of firm impulse control and complying with social conventions.

Arnett and Tanner's (2006) conceptualization of emerging adulthood is backed up by empirical research. Work by Cohen, Kasen, Chen, Hartmark, and Gordon (2003) highlights the gradual nature of the transition to adulthood. They found linear increases over time in the dimensions of independence in residential, financial, romantic, and parenting domains for both males and females, and the consolidation of adult status closer to the end of the third decade of life (late 20s) rather than the second (late teens). Other research has found that cognitive-emotional-behavioral development often continues in important ways during emerging adulthood, and that the period is one of especially heightened vulnerability resulting from disjunctions between the developing brain and behavioral/cognitive systems that mature along different timetables under the control of both common and independent biological processes (Steinberg, 2005).

Further research has found that even though adolescents may be able to show the same level of cognitive ability as adults in making decisions, they may make different decisions because they are more likely than adults to be affected by psychological factors, such as emotions of the moment and the desire to be accepted by peers. The evidence suggests that emerging adults experience difficulty maintaining balanced cognitive-emotional representations, especially if emotions are strongly activated, as when issues of security and survival are threatened (Arnett & Tanner, 2006). Findings from studies by Greenberg, Schimel, Martens, Solomon, and Pyszczynski (2001), and Pyszczynski, Greenberg, and Solomon (1999) suggest that emerging adults continue to be easily swayed by their emotions, which distort thinking in self-serving and self-protective ways.

In terms of the ability to maintain healthy and balanced interpersonal relationships, research has found that higher levels of ego development (usually achieved during the later stages of emerging adulthood) are related to greater skill in negotiating needs for autonomy/relatedness and in balancing relationship dimensions in close peer and intimate relationships (Schultz & Selman, 1998). A study by Scharf, Maysseless, and Kivenson-Baron (2004) examined the association between attachment representations and successful coping with developmental tasks of emerging adulthood. These tasks included coping effectively with the home-leaving transition, advancing in the development of the capacity for mature intimacy in friendships and romantic relationships while maintaining close and autonomous relationships with parents, and developing a sense of efficacy and individuation. They found that although these developmental tasks begin to evolve before late adolescence, they are a more central and salient part of emerging adulthood functioning during the third decade of life (late 20s).

This evidence from developmental research cited above on young teen's transitions to adulthood, including their living arrangements, educational patterns, and entry into the work force indicates that few

young people in the U.S. are ready to assume adult roles and live “independently” before their mid-twenties. Despite these findings which support a phased and delayed transition to adulthood for young people extending well into the third decade of life, child welfare policy in the U.S. continues to convey the expectation that youth in foster care should assume the responsibilities of adulthood at the early age of 18 when they are expected to “age out” of foster care to “independent living”. These expectations are inconsistent with the practical reality of young people’s lives in the 21st century, and it is essential we hold the same high hopes for youth in foster care as we do for our own children in terms of connections, living situations, and expectations for their future (Louisell, 2009).

### 3. The importance of social capital in emerging adulthood

Successful youth development is inextricably linked to relationships with the family of origin that influence developmental trajectories and life changes in adulthood (Arnett & Tanner, 2006; Cooney & Kurz, 1996). The family of origin functions as a base of operations for the explorations that occur prior to adulthood, both literally (through co-residence in a parental household, parental financial subsidies, and other material support) and figuratively (through the availability of parents and kin as sources of wisdom and guidance). Adolescents on the path to early adulthood rely upon their families for myriad forms of support. This support is critically important in the process of identity development, and may be manifest in multiple forms, such as instrumental, emotional, or informational support (Collins, Paris & Ward, 2008). For example, family relationships guide a young person’s expectations, feelings, information processing, as well as emotion regulation in situations that are attachment related (Aquilino, 2006; Scharf, Mayseless, & Kivenson-Baron, 2004).

Coleman (1990) uses the concept of “social capital” to designate this complex social support system that parents (or significant other adults in the child’s life) garner to advance their children’s chances of success in life. Social Capital Theory (Coleman, 1990) refers to these relational networks, social trust, and norms as fundamental forms of social capital. Social capital describes an interpersonal resource upon which individuals can draw to enhance their opportunities in life (Putnam, 1995, 2000). It includes obligations, expectations, and trustworthiness embodied in social structures, the potential for information in social relations, and norms and effective sanctions. It is formed as a result of relationships between parents and children, and is enhanced when the family is embedded in social relationships with other families and community institutions. Social capital conveys benefits to individuals within this social network through the provision of information, influence and control, and social solidarity (Sandefur & Lauman, 1998). Social capital theory emphasizes the importance of social patterns of acceptable behavior that support desirable social outcomes in that they provide for the exchange of information that facilitates outcomes desirable to group. Without social networks there is no possibility for the exchange of information or the enforcement of norms that facilitate collective goals (Goddard, 2003). According to social capital theory individuals engaging in relationships characterized by high levels of social trust are more likely to openly exchange information and to act with caring and benevolence toward one another than those in relationships lacking in trust.

High levels of social capital in a child’s life have been linked to more positive life outcomes and productive personal outcomes such as occupational viability, individual health and psychological well being (for a review, see Baker, 2000). Furstenberg and Hughes (1995) showed that social capital, measured as parents’ social investments in their children and the community, increases children’s odds of graduating from high school and attending college. Findings from longitudinal studies of the associations between parents’ support for, and adolescent progress toward, separation–individuation reveal that healthy separation–individuation predicts adolescent adjustment and the ability to

gain adult-sufficiency in emerging adulthood (Allen & Hauser, 1996; Bell, Allen, Hauser & O’Connor, 1996). Further research has indicated that forms of parental support are correlated with adolescents’ sense of self-worth and adjustment (Scholte, van Lieshout, & van Aken, 2001), and life satisfaction (Young, Miller, Norton, & Hill, 1995), and that smaller social support networks (less social capital) are associated with higher likelihood of homelessness (Reilly, 2003).

Family relationships influence emerging adults’ psychological development (including adjustment to new roles, health and risk-taking behaviors, capacity for intimacy, and identity formation), and autonomous/secure states of mind with regard to attachment relationships emanating from positive parent–child experiences are carried forward into adult intimate relationships and the capacity for establishing healthy adult interpersonal skills (Masten, Obradovic & Burt, 2006; Scharf et al., 2004). In addition, a number of studies have pointed to the importance of parental investment in explaining diverse patterns of coping with social and economic disadvantage in adulthood (Furstenberg & Hughes, 1995; Garnezy, 1985; Williams & Kornblum, 1985).

Individual differences in temperament, attachment history, or traumatic interpersonal experiences appear to be critical factors in the degree to which young adults are able to garner and utilize social capital (Labouvie-Vief, Zhang, & Jain, 2003; Mikulincer & Shaver, 2001). A large proportion of youth who age out of foster care experience significant social capital deficits. Unconnected to committed and permanent adults in their lives they do not have the benefit of their birth parents’ preparation for the adult world. By its very nature, foster care disrupts a youth’s relationships with parents and extended family (Freundlich, 2009). A significant proportion of youth in care (particularly those living in out-of-home care situations such as residential treatment facilities and group homes) have few or no relationships or connections with parents, extended family members, or significant other adults who can provide the needed social support to make a successful transition to adulthood. Since the family unit is the central provider of lifelong relationships for children (Collins et al., 2008), foster youth without families do not have the comfort and security that belonging to a family network brings, and they lack models for creating resilient families, successful work lives, and strong cultural and ethnic identities. Importantly, as they approach adulthood they lack a vital safety net (Freundlich, 2009).

For older foster youth (ages 16–18) many child welfare agencies have long since discontinued their efforts to sustain the youth’s relationships with family, reconnect youth with family members with whom contact has been lost over time, or assist youth in the developing of new relational networks with caring adults who can become “family” for youth as they enter emerging adulthood. In addition, because of their histories of child abuse and neglect, many youth preparing to leave foster care have physical, mental health, and developmental issues that elevate the importance of having caring committed adults available to support and guide them. They face the very real risk of aging out of qualification for the kind of help that most young people in modern societies require and receive as they establish themselves as independent young adults. The absence of strong “social scaffolding” in the lives of foster youth aging out of care is, no doubt, the critical predictor of the deleterious post-foster care outcomes that research has recently uncovered. The pursuit of enduring relationships, alongside the delivery of support services, is essential in “permanency oriented” child welfare services (Kerman & Glasheen, 2009).

### 4. Examining independent living programs

Adolescents comprise a significant proportion of the foster care population in the United States. In 2006, 40% of children in foster care, comprising more than 190,000, were age 13 and older, and one-fifth of the children were older adolescents 16 and older. Over the past decade, the number of youth who age out of foster care has steadily increased. In 1998 17,000 youth “aged out” of foster care; by 2006 that



number had increased by 50% to more than 26,000 youth (*Kids are Waiting*, 2009). In 2006, only 32,000 youth ages 12–20 (or 14%) lived in kinship family foster homes, while 35% of youth lived in group homes, institutions, or supervised independent living (U.S. Department of Health and Human Services (2008)). *Freundlich* (2009) notes that most youth in care live in group homes or institutions that do not provide opportunities for them to form the kind of lasting relationships with responsible adults that will help them move into adulthood.

The primary federal policy designed to assist youth with the transitioning out of foster care is the Foster Care Independence Act of 1999 (P.L. 106–169) (also known as the John H. Chafee Foster Care Independence Program (CFCIP)) which was intended to provide resources to states to develop programs and services to assist youth to establish independence after leaving care. Although CFCIPs provide a range of services that could be expected to prepare youth for the transition into adulthood on some functional dimensions, data have shown that only about two-thirds of eligible foster youth receive independent living services, with the quality of services varying significantly among states (*Courtney*, 2005). Furthermore, recent evaluations of independent living programs have found few impacts of CFCIPs on any measureable successful outcome for youth exiting care, leaving evaluators to conclude that there is no reason to believe that the services have a significant positive impact on any of the concrete indicators of successful transition to adulthood, such as educational attainment, employment, earnings, and avoidance of economic hardship, etc. (*Courtney & Zinn*, 2008). These findings, combined with research findings reported earlier on child cognitive, emotional, and behavioral development, have led scholars to raise doubts whether a healthy or successful adult by any definition truly lives “independently” from others and is self-reliant in meeting their needs at any age, let alone age 18 (*Iglehart*, 1994; *Reindal*, 1999), and in child welfare circles the term ‘independence’ has recently been rejected as a policy and practice goal in favor of ‘interdependence’ as a synonym for self-reliance and interpersonal autonomy (*Samuels & Pryce*, 2008).

Current child welfare philosophy is evolving to the position that successful transition from care is not only dependent on effective independent living skills, but is likely to be dependent on other aspects of child welfare policy implementation within the service system (*Collins et al.*, 2008). The CFCIP and the programs interventions it supports do not specifically address assisting youth with reconnection to birth family, kin, and other significant other adults in their lives that will be the permanent safety net for them in the future (*Collins et al.*, 2008). Research suggests that many youth exiting care have a need unforeseen in Chafee, i.e., enduring, supportive relationships (*Kerman & Glasheen*, 2009). *Iglehart* (1995) notes that while independent living programs may offer the skills and knowledge needed for successful emancipation, it is not clear to what extent if any these programs can combat isolation and provide social support.

Although at one time it may have been a developmentally appropriate expectation for a young person to be on their own at age 18, demographic evidence clearly indicates that in contemporary U.S. society young people are at a decided disadvantage if they lack the support of their family, or a family like unit (*Aquilino*, 1996; *Avery & Freundlich*, 2009; *Greeson & Bowen*, 2008; *Goldscheider & Goldscheider*, 1993; *Mendes*, 2006). The failure of the foster care system, and independent living programs in particular, to prepare youth for connectedness to caring adults who can provide the supportive safety net as they explore adulthood is well-documented (e.g., *Courtney et al.*, 2001; *Georgiades*, 2005; *Mann-Feder & White*, 2003; *McMillen, Rideout, Fisher, & Tucker*, 1997).

## 5. Hearing from youth in care

The search for permanence, including a reliable, lifelong parenting relationship and the opportunity to maintain contact with family and

other important people, is described by youth and foster alumni as a core need to be balanced with the simultaneous need for independence (*Samuels & Pryce*, 2008). Foster youth report rarely being involved in the decisions made about their short- or long-term care plans made for them (*Unrau*, 2006), and report having minimal, if any, control over maintaining core relationships with those to whom they are attached, most notably siblings (*Harrison*, 1999; *Herrick & Piccus*, 2005; *Mullender*, 1999). In a study by *Geenen and Powers* (2007) current and former foster care youth emphasized the importance of taking part and having a say in the important decisions that impact their lives while in care, and the importance of caring long-term relationships with adults as they transition into adulthood. Former foster youth in the study reported the absence of caring, stable relationships in their lives and feelings of isolation and disconnectness after exiting from care.

Caseworkers interviewed in the *Geenen and Powers* (2007) study recommended that questions regarding a foster youth's contact with birth parent(s) be revisited as the child becomes older and immediate concerns regarding safety or care-taking are less of a concern. The fact is that, although many child welfare systems have worked diligently to become more family centered, there remains a fundamental tension between child protection and family services (*Collins et al.*, 2008) that undermines case work focused on reconnecting foster teens with their birth family and extended kin. *McMillen and Tucker* (1999) and *Freundlich, Avery, Munson and Gertenjang* (2006) raise excellent questions in wondering whether the child welfare system does not consider these family members as placement settings while the youth is still in care given the reported incidence of the extent of teens' reconnection with birth families after they leave care.

## 6. Deleterious consequences of not achieving permanency

Young people “aging out” of the child welfare system are undergoing a dual transition—one from the care of the system to autonomy and a second from childhood to adulthood—and they face numerous challenges in making this transition and many experience a range of negative outcomes (*Shook, Vaughn, Litschge, Kolivoski, & Schelbe*, 2009). With overwhelming consistency, research suggests a startling constellation of increased risk factors for deleterious outcomes for youth aging out of foster care (*Samuels & Pryce*, 2008). These include homelessness, early pregnancy, incarcerations, victimizations, and poverty (*Barth*, 1990; *Courtney et al.*, 2005).

They quickly confront the harsh realities of life as an adult when they lack family relations and resources to support them (*Courtney & Hughes-Heuring*, 2005; *Freundlich*, 2009; *Shook et al.*, 2009), and are at high-risk of failing to meet even minimal levels of self-sufficiency and acceptable behaviors (*McDonald, Allen, Westerfelt, & Piliavin*, 1993). Growing literature on foster youth outcomes illuminates a legitimate and very worrying concern that this population will experience their adulthood in the context of other public service systems and institutions (*Samuels & Pryce*, 2008).

Two recent studies examining the experiences of youth following their exit from care found that these youth often struggle to complete their education, they frequently have significant health and mental health problems; they often are unemployed or underemployed and face poverty; and, as a group they are more socially isolated than their non-foster care peers (*Courtney & Dworsky*, 2005; *Pecora et al.*, 2005). They often have had contact with the justice system, live in socially disorganized neighborhoods that have higher rates of crime, experience substance abuse or mental health problems, leave the child welfare system with educational deficiencies, and are either unemployed or experience employment instability (*Courtney et al.*, 2005; *Vaughn, Shook, & McMillen*, 2008).

In a similar study *Shook et al.* (2009) found that youth often attach to ‘deviant peer relationships’ for support after exiting care, and youth with high levels of deviant peer affiliations were more likely to be

fired from a job, to possess a diagnosis of antisocial personality disorder, to report higher levels of substance use, and to report being arrested than youth in the low or medium deviant peer affiliation groups. It is interesting to note that youth in the low deviant peer affiliation group had higher levels of family support and lower levels of neighborhood disorder than youth in the other two classes.

Foster youth also experience risk related to socio-emotional well being. A recent collaborative study by Harvard Medical School, Casey Family programs, and state agencies in Washington and Oregon found that former foster youth (ages 19–30) demonstrated post traumatic stress disorder rates up to twice as high as U. S. War Veterans (Pecora et al., 2005). In a comparative study, Lawrence, Carlson, and Egeland (2006) report foster youth in their sample indicated mental health and behavioral problems at rates more severe and more frequent than children from similar backgrounds (e.g., maltreatment) who were not placed in foster care. Even in studies where mental health is one of many outcome domains assessed, foster youth exhibit depression (Barth, 1990) and other psychological health problems at rates higher than in the general populations (Courtney & Hughes-Heuring, 2005).

Numerous studies have shown that a high percentage of the homeless population on the streets of U.S. cities and towns are former foster care youth. For example, the Coalition for the Homeless reported that 60% of the homeless in New York City's Municipal Shelters have some history of foster care (Coalition for the Homeless, 1989). Shaffer and Canton (1984) in their study entitled "Runaway and Homeless Youth in New York City" found that 50% of the homeless young people who came to shelters had previously lived in a setting provided by the Child Welfare System, either in a foster home or a group home. In a study of 168 youth interviewed at Covenant House, the only youth shelter in New York City that accepts youth up to the age of 21, it was found that 27% of them had spent time with a foster parent, and another 43% had spent time in foster group homes (Margetson & Lipman, 1990). The National Foster Care Awareness Project reported that 40% of the nation's homeless were in foster care as children (National Association of Social Workers, 1991, October). In addition, in a survey conducted by the Chicago Coalition to the Homeless (1989) approximately 44% of homeless youth in Chicago report having been wards of the state. Furthermore, 46% of youth in runaway and homeless shelters in New Jersey reported that they had lived in New Jersey's foster care system in the previous year before they entered the shelter (data provided by New Jersey Division of Youth and Family Services, 2005).

Even more disturbing are results from research indicating that there is an intergenerational component to post-foster care homelessness that could well impact future generations as well. Homeless parents with a history of foster care are far more likely than other parents to have their own children in foster care. The National Alliance to End Homelessness conducted a survey of 21 housing provider organizations serving 1134 people in the programs during a two week period (Roman & Wolfe, 1995). They found a drastic difference between homeless parents who grew up in foster care compared to homeless parents who did not grow up in foster care. Of those who had no foster care history and were homeless, 27% had at least one child who had a foster care history or was in foster care. Of those who had a foster care history and were homeless, 77% had at least one child who had a foster care history or was in foster care. Furthermore, one of the main precursors to any child entering foster care is having an active case open with the local Child Protection Service (CPS). The Institute for Children and Poverty (1997) examined the difference between homeless parents who did and did not grow up in foster care in New York City. They found that homeless parents without a history of foster care had active cases with CPS 29% of the time, while 19% of them had been previously homeless. On the other hand, homeless parents with a history of foster care had active cases with CPS 73% of the time, while 49% of them had been previously homeless.

## 7. Conclusions regarding youth permanency and child welfare practice

State and federal policy and support programs for youth aging out of care currently reflect a focus on preparing youth for "independent living" at age 18 and, until recently, have had a resultant lack of focus on developing and nurturing social capital prior to exit from care. In recent years there has been a growing awareness in the child welfare community (as evidenced in the literature and Federal grant RFPs) for the need to develop and implement policies and practices that ensure that youth have permanent committed relationships (adoption, guardianship, or other permanent outcomes) with adults before they leave care. This awareness has been accelerated by recent studies examining the post-foster care functioning of youth. These studies have provided convincing evidence that most youth who age out of foster care at 18 simply cannot make it on their own (Courtney et al., 2005; Courtney & Dworsky, 2006; Furstenberg et al., 2005; Masten et al., 2006). They simply do not have the developmental maturity needed for successful entry into adult roles—especially youth with emotional, psychological, educational, and behavioral deficits resulting from early childhood experiences of abuse, neglect, and abandonment. Furthermore, there is a growing awareness that "independent living" is simply not a feasible option for the majority of youth in foster care who, unlike children who are not in foster care, lack the social scaffolding of stable family and community networks to support them (Voices Issue Brief, 2004).

Of particular concern to the child welfare community are youth aging out of foster care who are members of racial/ethnic minority groups, who comprise the majority of youth aging out of the system. The transition to 'independence' is particularly difficult for members of racial/ethnic minority groups because, in addition to personal identity exploration facing all emerging youth, these youth also must deal with identity issues in relation to their racial/ethnic heritage—and these racial/ethnic identity domains are far more central for youth of color than for Caucasian youth (Phinney, 2006; Phinney & Alipuria, 1990). For youth of color, a sense of membership in an ethnic, racial, or cultural group is an underlying issue that pervades and influences progress toward adulthood. In addition, these youth are frequently faced with discriminatory attitudes and evidence of their lower status and power in society which forces them to have to continually negotiate their sense of self in relation to other groups.

Another accelerator of this change in focus in the child welfare community is the consistent finding from studies of youth leaving care that they frequently connect to their families of origin, including residing with family members, after leaving foster care (Courtney & Dworsky, 2006; Courtney et al., 2001; Iglehart & Beccerra, 2002). Because homelessness is a significant threat to this population (Park, Metraux, Brodbar, & Culhane, 2004) successful reunification with kin prior to exit from care may save these youth from being on the streets. Although family reunification is a core objective during the time children and youth are in care, the process of reunifying with families after leaving care is outside the scope of the child welfare system and often neglected in child welfare case planning. Because these post-foster care connections with family occur outside the child welfare system little is known about the process and outcomes of these reconnections (Collins et al., 2008).

While permanency has for decades been a core principle of child welfare work, its accepted definition within the child welfare community in terms of lifelong connections to kin and fictive kin appears to be gaining even greater currency (Collins et al., 2008). This is evidenced in a definition of permanency offered by Frey and Greenblatt (2005, p. 3) "Permanency" is about having an enduring family relationship that is safe and meant to last a lifetime; offers the legal rights and social status of full family membership; provides for physical, emotional, social, cognitive, and spiritual well being, and assures lifelong connections to birth and extended family, siblings, other significant

adults, family history and traditions, race and ethnic heritage, culture, religion, and language. As early as 2000 Charles and Nelson (2000) discussed the importance of permanency for older adolescents in foster care in terms of the need to help youth make lasting connections to family, friends, and supportive networks, and Bussiere (2006) recommends integrated service plans that create permanency for older youth in terms of social supports, involving older youth as participants in their own permanency plans, identifying caring and supportive adults, exploring adoption options, and including family members in reunification plans. This “social capital” based definition of permanence is being driven by research that is just beginning to explore supportive networks and relationships as protective factors against many negative outcomes predicted for this population (Massinga & Pecora, 2004; Perry, 2006; Propp, Ortega, & NewHeart, 2003).

So, while general resilience and youth development literature outside of foster care contexts has long identified the benefits for youth of being connected to supportive adults, including its positive effects on self-esteem, psychological health, educational achievements, and social skill development (Massinga & Pecora, 2004; Perry, 2006; Samuels & Pryce, 2008), it is slowly developing as a priority focus in the child welfare literature and research. For example, the presence of at least one caring adult who offers social support and connectedness was identified as a protective factor for youth across a variety of risk conditions in studies by Fraser, Kirby, and Smokowski (2004) and Werner and Smith (2001), and studies by both Munson and McMillen (2007) and Ahrens, DuBois, Richardson, Fan, and Lozano (2008) showed that the presence of a natural mentor was significantly associated with foster youth's positive psychological outcomes.

Commensurate with this refocusing of the definition of youth permanence in child welfare has been the emergence of “best practice” strategies for attaining that permanence for youth aging out of care (National Resource Center for Foster Care and Permanency Planning & Casey Family Services, 2004). The need to achieve and sustain family-based permanence for youth has prompted the development of child welfare practices that: help young people and their families cope with trauma, separation, and other challenges that can be barriers to reconnecting with kin and fictive kin; fully engaging youth in their own permanency planning; and serious reconsideration of the role of birth families as planning and permanency resources (Freundlich, 2009). Practice models are calling for youth-centered permanency planning teams: developing an individual team for each youth; asking the youth to identify important members of their own team; making the youth the central team player on the team; joining youth, birth parents, foster parents, family members, and other important adults together with professionals on the planning team; and facilitating a pro-active and continuous teaming process until youth reach permanence rather than episodic or crisis-driven meetings (Frey, 2009). In fact a variety of best practice model programs are using family teaming to involve youth and families in the permanency process (e.g., Permanency Teaming, Team Decision Making, Family Group Decision Making) (Kerman & Glasheen, 2009). Frey (2009) further suggests fully involving youth in their own permanency plans by: asking them whom they love, who loves them, and to whom they want to be close and connected and asking them about blood and legal relatives, informal family members and other significant adults (teachers, coaches, mentors, etc.) they are close to.

## 8. Promising practice model

Attention is now turned to a model demonstration project, funded by the Children's Bureau (DHHS) during 2004–2008, that used a “social capital building” model to achieve permanence for teens at risk of aging out of care unconnected to permanent families. The program model is based in the assumption that the strongest, most secure, and most enduring “social capital” for aging out of care is a permanent

nuclear and extended family achieved through adoption or other permanent commitment.

### 8.1. Target population and approach

The “Permanent Parents for Teens” project was a federally-funded demonstration effort funded through the Children's Bureau at the U.S. Department of Health and Human Services. The goal of the project was to find permanent adoptive parents for teens that were freed for adoption or to find committed permanent parents who would morally adopt teens who are not freed but in danger of discharge from foster care to homelessness. Using a multi-prong approach, the project tackled the problem of finding permanent homes for referred teens in the care of New York City's (NYC) foster care system before they were discharged from care. Target teens were currently residing in congregate care facilities in and around the NYC metropolitan area. The project utilized a partnership between NYC's Administration for Children's Services (ACS) and the grantee agency *You Gotta Believe*. Teens were referred to the project by staff at both the residential treatment facilities and the staff at the DSS.

### 8.2. Project model

The project model out stationed specialized staff at fifteen different residential facilities and group homes in and around New York City and Westchester County, including eight residential treatment centers and six group homes operated by NYC's Administration for Children's Services' (ACS) Office of Direct Care, and ACS's Office of Youth Development (OYD). Through the regular presence of project staff out stationed in these facilities they were able to regularly interact with facility social workers and resident teens and build up ongoing and consistent relationships in support of the youth. They were able to provide on-sight training about teen permanency, attend staff meetings for teens, and become a part of the management culture in these programs that facilitated their efforts to refocus planning efforts on youth permanency.

### 8.3. Child-specific recruitment approach

The project accepted referrals of teens residing in these, and other, congregate care facilities. Specialized case-work activity focused on a child-specific recruitment approach called Permanency Action Recruitment Teams (PART). PART meetings were convened for all teens referred to the project, unless a permanent resource had already been identified for them at the time of referral. The PART meeting brought together all parties involved in the permanency planning process for the teen, including individuals in the teen's life who could potentially be a permanency resource for them, and focused on goal setting and strategy development for achieving permanency for teens prior to their exit from care. The PART meetings were attended by the teen, the teen's social worker, facilities staff, and other individuals involved in the teen's life (relatives, acquaintances, etc.). The meetings were led by the family permanency advocates, a teen permanency advocate (both project staff members), and the teen themselves. Prior to a PART meeting the family permanency advocate would work diligently with the teen to identify significant others (kin, fictive kin, friends, acquaintances) in their life with whom they had a positive constructive relationship and who could potentially be a permanent resource for them. This included scouring their case files for potential names of individuals who previously had been foster parents, friends, teachers, etc. The staff member then contacted those individuals and invited them to take part in the PART meeting, made home visits to people who couldn't make a day-time meeting, offered to arrange to get people who know the teen to special meetings, and reached out to relatives not previously considered as a permanency resource.

In cases where teens were unable to identify potential permanency resources in their lives at the time of referral, project workers immediately involved the teens in opportunities for sharing time and space with prospective permanent parents including: hiring the teen as a training consultant and panelist during the Adopting Older Kids And Youth (A-OKAY) classes; hiring a teen to work around the office where waiting families often came to go through books, look at pictures, use the Internet, etc.; invited waiting teens to all agency events such as holiday parties (Halloween and Christmas), summer picnics, trips to amusement parks and minor league baseball games, etc., which offer waiting teens and parents an opportunity to share the same time and space; and, setting up individualized special events that provide an opportunity to bring together youth and prospective parents, such as talent shows, craft events, etc.

#### 8.4. Parent education and training

The grantee agency *You Gotta Believe*, a licensed foster care agency, held certification trainings in eight different locations in and around the New York City area convenient to all families and at after-hour and weekend times convenient to families. These trainings were heavily advertised throughout the community and were open to anyone who heard the message and decided to attend the trainings, included those who were invited by a project worker, a friend or neighbor, or invited by a teen. Attendance at the trainings was completely voluntary and anyone who walked through the door was welcomed to participate.

These trainings formed a critically important role in the project model since they focused on parent preparation for teen placement in the home. The rotating nature of the ten separate classes (30h of training) meant that families could join the trainings at any time and start the classes in any order, providing maximum flexibility for prospective families. These trainings were designed to prepare new families for unconditional commitment to teens and to increase the receptivity of trained families for youth placement in the future. Through these trainings the project was able to license the family, place the teen into the licensed home, and then transfer a fully NYS-approved home to the agency that has the teen in its care until the teen was legally adopted.

Four of the ten A-OKAY classes were specifically focused on older child adoption: Class 1: Experienced Parent Panel: the panel brought together three or four experienced parents who had adopted teens to talk about both the rewards and challenges of raising teens permanently and about making lasting commitments. Class 2: Youth-in-Care or Former Youth-in-Care Panel: this panel brought together three or four youth in care or former youth in care to talk about how important lifelong permanency is for them. Class 3: Adolescent Development: this very unique workshop was developed by *You Gotta Believe* staff to look at the developmental needs of adolescents. The class addresses the uniqueness of moving into a home from a differently structured congregate care facility, the internal conflict within the teen about wanting to attach to their new family, and their struggle for independence. Class 4: Behavior and Unconditional Commitment: this class addresses how important it is to make a lifetime commitment to a teen regardless of their behavior. It helps prospective parents understand that so called “bad” behavior needs to be treated, and that re-abandoning the child should never be part of that treatment. The class stresses the importance of treating any teen’s “bad” behavior with the identical commitment to that offered a birth child.

#### 8.5. Professional trainings

Project staff also provided ongoing trainings for staff at the congregate care facilities where they were out stationed. These trainings emphasized the urgent need to get every teen into a permanent home before their discharge from foster care. Information was shared during these trainings about the strong connection between aging out, homelessness, and other deleterious outcomes

for youth. The trainings were designed to empower staff at all levels to help explore the constructive adults in the teens’ lives, including opening these staffers up to the possibility of being a parent themselves. The trainings emphasized that one of the primary obstacles keeping teens out of permanent homes is worker attitudes and beliefs about the possibility of permanent parents for older teens.

Project staff also worked with New York City’s Office of Youth Development and other agencies serving New York City teens to encourage them to allow project staff to bring in panels to talk to their youth about permanency. These panels, organized through the Project’s “Speak-Out Bureau”, addressed a primary concern many teens have—a strong belief that nobody wants them. The panels included teens and young adults who were adopted as teens, certified prospective parents who wanted to adopt teens, as well as new parents who recently received the placement of a teen. The goal of the panels was to help teens understand that not only are teens getting permanent homes—many from the constructive adults already in their lives—but that there are parents who come forward to do this as well. The project’s ‘Speak-Out Bureau’ gave staff, parents, and teens an opportunity to share their stories with the rest of the child welfare community. It was believed that the stories of these individuals would have more impact on the target audience than training alone, and that personal testimony would be a powerful influence on attitudes, beliefs, and behaviors.

#### 8.6. Post-placement services

After a teen was successfully placed in a home by project efforts, an experienced adoptive parent (Shadow Worker) was assigned to the family to make regular contact with them for as long as the family needed help and guidance. In addition, the staff held ongoing monthly Parent Support Groups for any parent who had a teen placed by the project in their home, and Shadow Workers and Permanency Advocates Parents fielded calls from parents or teens whenever needed. This project element filled a major child welfare service gap by providing critical post-placement support services that were significant in securing the stability of the teen placement.

### 9. Evidence-based practice

The project model was a highly successful one in terms of teen permanency outcomes and evaluation data indicate that the strategy of home finding used in this project, i.e., exploring currently existing kin, fictive kin, and other significant relationships already existing in the teen’s life at the time of referral, is a highly successful recruitment strategy for older teens in care. In addition, evaluation results indicate that the dual project strategy of child-specific recruitment and focused parent training (A-OKAY training and certification) was primarily responsible for the high teen placement rate in this demonstration project.

#### 9.1. Teen permanency placements

A total of 199 teens were referred to the project during the funding period. The majority of referred teens were living in institutional settings, residential treatment facilities (75.9%) and group homes (18.6%). The average age of referred teens was 15.7 years and, on average, these teens had spent 7.4 years in foster care and 2.7 years in their current congregate care facility. Many teens referred to the project had multiple and severe special needs, including emotional, behavioral, learning, psychiatric, developmental, and medical/physical needs. The success of project efforts is indicated in the evaluation result that 98 of the 199 referred teens (or almost 50%) were permanently placed into homes by end of the project period.

## 9.2. Adoptive parent training

The evaluation design was unique in that it allowed for a natural experiment to occur regarding the A-OKAY parent trainings. This natural experiment provided strong and convincing evidence of the success of a project model in which child-specific recruitment is paired with targeted parent training. The grantee agency, *You Gotta Believe*, conducts their A-OKAY training for both project parents (i.e., potential permanency resources identified by referred teens) and other parents who are either referred to the agency for foster care training or who turn up at the trainings simply interested in learning more about adoption and fostering. Documentation was made of all people who started the A-OKAY training at any of the agency's training sites during the 4 years of the grant. Individuals were then classified into people who knew a specific teen needing placement at the start of their training, and people who did not know a specific teen they were interested in at the time of training. In evaluating the data presented below it is important to note that the project's outreach to both the general public unconnected to a specific teen, and to anyone else who might know a teen, is to actively encourage them to take the A-OKAY trainings. The project did not screen anyone who turned up to the trainings, and everyone from the community was welcomed. In fact, outreach activities advertised the classes to the general public on the *You Gotta Believe* radio program, TV program, and literature to come and "Learn about Adopting Teens".

In evaluating the data presented below stark differences are found in training completion rates, home study completion rates, licensing rates, and teen placement rate between the two groups (Table 1).

Throughout the 4 years of the project a total of 1143 people walked through the A-OKAY training doors and participated in an orientation session. Approximately 449 (or 39%) of those people completed the 30h of training, 190 (or 17%) completed the training and got licensed, and 120 (or 10%) completed the training, got licensed and got a teen placed with them through the project efforts. A little more than 10% of the people who walked through our door had a teenager placed with them.

The interesting contrast, however, and one that has significant implications for teen recruitment efforts, is the difference that emerges in training outcomes when people are classified by whether they knew a specific teen at the time of training initiation or not. Of those people who did not start the training with a particular teen in mind (987 or 86% of all people who walked through the doors), 324 (or 33%) completed the 30h of training, 106 (or 11%) completed the home study, and only 37 (4%) got a teen placed with them. In stark contrast, of those people who started training knowing a specific teen (154 or 14% of all people who walked through the doors), 125 (or 81%) completed the 30h of training, 84 (or 54%) completed a home study, and 83 (or 53%) got the teen placed with them. The numbers in the last column of the table tell an important story. Overall 63% of the people who completed the training and their home study had a teen placed with them, but when you classify those parents by whether they had a particular teen in mind at the initiation of the training, only 35% of those who did not know a teen completed the home study and had a teen placed with them while 99% of those who knew a specific teen at the time of training initiation completed the home study and had a teen placed in the home.

These comparative data really help to dispel several myths about recruitment and training. The first myth is that if you recruit someone

a teen knows, you should not ask them to take a 30-hour parent preparation class about how important it is to remain unconditionally committed because that would turn parents off. The evaluation data indicate that 81% of the people who walk through the training doors who knew a teen completed the entire 10-week, 30h training. Another myth is that there are a large number of people from the teens' lives that are not qualified to be permanent parents. The data indicate that over half of the parents were qualified enough to complete a home study and get licensed.

## 9.3. Other project elements contributing to this 'promising practice' model

One of the most important strengths of the project was the background of project staff. All staff had significant personal experience with older child adoption (i.e., they had been adopted from care as teens themselves and/or were adoptive parents of older youth) and consequently had deep personal knowledge of the teen placement process. Project staff were selected based on particular personality characteristics of motivation, empathy, the ability to engender trust and confidence, and excellent management skills which facilitated continuity and follow-up in service delivery. In addition, staff were selected based on their firm belief that every child in care deserves a home and that there is a home for every child in care. This belief was unwavering in all staff members and resulted in the significant success of the project in terms of goal outcomes. Furthermore, the staff management model used on this project greatly contributed to enabling the talented staff members to do their job effectively. The fact that staff were out stationed at the congregate care facilities rather than operating out of a central office enabled them to develop close and ongoing relationships with both the teens and congregate care staff members, facilitated time management, and allowed them to meet the needs of teens and parents at convenient locations and on their own time schedules.

## 10. Other collaborative efforts

Farmer (2008) reports on another similar child-specific recruitment effort involving *You Gotta Believe* at Children's Village. The project serviced 69 teen residents (ranging in age from 13 to 20), all of whom had been in residential care for at least 5 years and were, more or less, poised to age out of the system without leaving care. They hired two permanency specialists to find homes for these youths. The approach they used was to find matches with individuals teens already knew and felt a special connection with, such as an aunt, uncle, for former foster parent by asking the teens themselves, pouring over the case records, and actively searching for leads. They worked with *You Gotta Believe* using a range of matchmaking efforts, such as using teens as panelists for educational seminars and orientations geared to prospective foster parents, but the most effective recruiting strategy was simply talking to the youth about anyone in their past or in their current sphere of connections with whom they might like to live. A critical part of this recruitment process was the 10-week A-OKAY parental training and licensing course offered by *You Gotta Believe*.

Table 1

	Number of entrants	Completed training	Home study completed	Teen placed in home	Percent completing training, the home study, and with a teen placement
Total	1143	449 (39%)	190 (17%)	120 (10.4%)	63%
Did not know teen	987 (86%)	324 (33%)	106 (11%)	37 (4%)	35%
Did know teen	154 (14%)	125 (81%)	84 (54%)	83 (53%)	99%

## 11. Current evolving “family-finding” technologies

Recent technological improvements have made it easier to locate missing family and important adults assumed lost (Louisell, 2009). The Homecoming Project began in 2003 as a five-year Federal demonstration project. In addition to seeking adoptive families the project also had the explicit goal of strengthening participating youth's connections to caring adults and the larger community by engaging in child-specific recruitment efforts. An analysis of project records and administrative data shows that 51% of these youth in the Homecoming Project achieved permanency during the funding period (Skrypek & Gerrard, 2009). Family-finding efforts for youth in residential care in Santa Clara County, CA located more than 220 relatives for eight youth by doing only 9 hours of family search work (Campbell et al., 2003, p. 15). In 2006 the California Permanency for Youth Project (CPYP) (Friend, 2009) created the Emancipated Youth Connections Project (EYCP) to assist twenty young adults who left the foster care system without sustained relationships to a caring adult. This 18-month project was tremendously successful in finding family or other caring adults to be lifelong connections. Data available for 19 of the 20 participants showed that: 139 new permanent connections were made with biological family members and 42 new permanent connections were made with non-biological family members. These results demonstrate that permanency can be attained for older youth in foster care through successful child-specific recruitment efforts such as those reported in this paper.

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# Lunch Time Presentation

New laws/ January 1, 2018





# Where have we been today?

- The Why of CCR
  - Every child should be in a family like setting and receive the quality parenting every day.
- CCR –legal
  - CFTs
  - Family Finding
  - Permanent plans
  - STRTPS
  - No more LTFC!
  - Transition to adulthood – 14+
- Outstanding questions



# New Laws

- Federal Families First Prevention Services Act of 2017
- Emergency placements
- Bills to Watch for RFA



# Families First Act – Abbreviated (103 pgs)

## Prevention Services

States can spend money on:

- Services to address mental health
- Substance abuse treatment
- In-home parent skill based parenting

Who is eligible:

- Parents or relatives caring for children who are candidates for foster care (would have to enter FC but doesn't because of preventative services)
- Parenting or pregnant youth in foster care

# Families First Act- Preventative Services

## Elements:

- Formal prevention plan required
- a strategy to keep kids at home or live temporarily with kin AND
- a list of services (trauma informed)

## Timeline:

- State can spend IV-E on prevention services for 12 months. Time starts the day the child is identified in the prevention plan as a candidate for foster care

# Families First Act – Preventative Services

**Funding:** Available for residential substance abuse treatment for parents and children. Must be a formal recommendation made for the placement (presumably by a judge) and the facility must provide parenting and counseling.

New funding starts in October 2019

# Families First Act- Congregate Care

Child care institution:

Means any private child-serving institution and any public-child serving institution that holds 25 or fewer children.

Act says that if a child is placed in one of these institutions, no IV-E foster care funding can be made beginning with the 3<sup>rd</sup> week of placement. (no reimbursement of placement dollars, admin expenditures can still be reimbursed.)

Carveout- exempts juvenile facilities involved in pre or post adjudication services, but cannot arrest youth for purposes of being able to house them in group settings.

# Families First Act – Congregate Care

## Exceptions:

IV-E placement dollars can be reimbursed beyond the 2 weeks in:

- A setting for prenatal, postpartum, or parenting supports for teen moms
- Supervised setting for a child 18 or older (continue to receive extended foster care funding)
- High Quality Residential Services- for youth who have been victims of trafficking or who are risk
- Quality residential treatment program (QRTP)

# Families First Act- QRTP

- Licensed
- Trauma informed treatment model
- Registered or licensed nursing staff and a nurse is on call at all times
- Inclusive of family members in treatment plans and programs
- Plans for at least a six-month window of support after discharge
- For long stays – 12 or 18 months – the actual “head of state” agency must sign off
- Could take until 2021 for these limits in some states.



# Families First Act - QRTP

- Within 30 days of a child being placed in a QRTP, a “qualified individual” must
  - assess strengths and needs of child,
  - determine whether the needs of the child may be met with family members or through a foster family placement, and
  - develop a list of child specific short- and long- term mental and behavioral health goals
- There must be a family and permanency team (Akin to our CFTs) to help with the case plan
- Qualified individual means: “trained professional or licensed clinician who is not an employee of the State agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State”

# Families First Act- QRTP

- Within 60 days of a placement of a child in a QRTP, the court MUST:
  - Consider the assessment, determination, and documentation by the qualified expert
  - Determine whether the child's needs can be met in a foster family, and if not, determine whether this QRTP “provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child.”
  - Approve or Disapprove of the placement
- As long as child remains in QRTP, at every status review hearing, evidence must be in the case plan about whether the child the placement is appropriate and meeting the needs in the least restrictive placement
- Implementation in October 2019 (revise 387?)

# Families First Act – Adoption/Reunification

## Adoption and Guardianship incentives

- started in 2014 with preventing sex trafficking and strengthening families act
- Rewards states for finalizing adoptions and guardianships
- This bill extends incentives to 2021

## Reunification

- Adds time-limited services under IV-E and takes away time limits under IV-B
- 15-month limit on funds once a child enters foster care is gone and funds can also be used to continue supports for 15 months after the child returns home

# AB 404 and SB 213

## FOR EMERGENCY PLACEMENTS

- People

- All person over 18 living in the home (NMD excluded)
- Any person over 18 regularly present in the home other than those receiving professional services .
- Any person over 14 who the department believes may have criminal record (at the county's discretion), but does not apply to children under the jurisdiction of the juvenile court

- How

- Conduct CLETS check and a check of allegations of prior child abuse and neglect
- If no criminal record, then child can be placed on emergency basis (WIC §361.4(b)(1))

# AB 404 and SB 213

If there are arrests:

- An investigation is required for any arrests under H&SC §1522(e) and a child cannot be placed until the county and courts have considered the investigation results and determined placement is in best interest of the child.

If there are convictions:

- A child cannot be placed until exemption is granted (WIC §361.4(b))
  - Exception: if deputy director or director or designee determines that placement is in best interest of child and party to case does not object, a child may be placed in the home on an emergency basis unless it was a conviction for a crime listed in HS §1522(g)(2)(A)(i-iii)

# AB 404 and SB 213

## FOR RFA:

Within 10 calendar days of CLETS or 5 business days of emergency placement (whichever is sooner), social worker shall ensure that a fingerprint check be done through DOJ

Who must submit to a criminal record check?

- Each RFA applicant and all adults residing in or regularly present in the home
  - Exception: (1) Adult friends and family who come into the home for no longer than a defined period of time provided they are not left alone with the child. RPP may allow adult friend/family to provide short term babysitting. (2) Parents of the child's friend who the child is visiting in the friend's home provided the friend, foster parent or both are present. (3) Individuals engaged by the foster parent to provide short-term care not to exceed 24 hours.

# AB 404 and SB 213

For RFA:

How the check is done:

- Receipt of fingerprint-based state and federal criminal offender record information search response
- If there is an arrest for PC 245, 273ab, 273.5, 273a(b), or any non-exemptible crime (H&SC §1522(e)), County MUST conduct an investigation before an exemption or clearance is granted. An arrest record must not be used to deny or rescind an approval unless the department investigates the incident and secures evidence of risk.
- If person is awaiting trial, including active warrant for arrest, it may cease processing criminal record information until the conclusion of the trial.
- If there is a non-exemptible conviction exemption cannot be granted and no RFA approval; if convictions are exemptible, then RFA approval only if exemption has been granted.

Emergency Placement (Relative/NRHM only)	Compelling Reason (May be anyone)
<p><b>Definition:</b> "Emergency placement" means a placement of a child at temporary placement (EMD) with a relative or extended-related family member (NRHM) prior to Resource Family Approval (RFA) pursuant to Welfare and Institutions Code (WIC) section 161.4, (b)(7)(F), current WIC 59.209 &amp; 59A.01.</p> <p><b>Differences: Background Check and Home Inspection</b> Prior to an Emergency Placement, a County:</p> <ul style="list-style-type: none"> <li>(1) Conducts a criminal background clearance check that includes a Child Abuse Central Index (CACI) and California Law Enforcement Incentive System (LEIS) for a relative or NRHM and adults residing at the home pursuant to WIC 9.20052. This is followed by a Sex Search (SS) (CSI) within 30 calendar days after placement is made. CACI is a name-based criminal check and could be inaccurate versus a Sex Search which is fingerprint based.</li> <li>(2) Conducts a brief home inspection which includes a County Inspector the home and grounds to determine that they are free of conditions that may pose an undue risk to health and safety of the child or NAD.</li> </ul> <p><b>Requirements SECTION 7.01: Emergencies Placement with Relative or NRHM</b></p> <ul style="list-style-type: none"> <li>• Within 5 business days after a child or NAD is temporarily placed with a relative or NRHM, a County shall: <ul style="list-style-type: none"> <li>◦ Exhaust funding options available to a relative or NRHM.</li> <li>◦ Provide a relative with a blank copy of form CW 2338 "Rights, Responsibilities and Other Important Information" and form CW 2337 "Application for California Work Opportunity and Responsibility to Kids (CalWORKS)" for all eligible children temporarily placed with the relative. <sup>1</sup> Such forms are not eligible for a CalWORKS payment on behalf of the child in this situation.</li> </ul> </li> </ul>	<p><b>Definition:</b> "Compelling Reason" means a decision to place a child with an applicant prior to approval as a Resource Family based upon the best interest of the child, to include ensuring a child's Family like connections.</p> <p><b>Differences: Background Check Assessment and Home Health and Safety Assessment</b> Prior to a Compelling Reason Placement:</p> <ul style="list-style-type: none"> <li>(1) RFA application has been assessed.</li> <li>(2) Home Health and Safety Assessment (as documented on RFA 04) has been completed and connections have been made and</li> <li>(3) The background check assessment of the applicant and adults residing or regularly present in the home has been completed. This includes Sex Search (CSI), Megan's Law Registered Sex Offender check, and an Administrative Action Records System (AARS)<sup>2</sup> and Licensing Information System (LIS)<sup>3</sup> checks, and if applicable, criminal record investigations and checks are based on investigations for serious arrests.</li> </ul> <p><b>Requirements SECTION 7.02: Placement Based on Compelling Reason</b></p> <ul style="list-style-type: none"> <li>• Complete the Permanency Assessment and prepare the Written Report within 90 calendar days of the date a child or NAD was temporarily placed with the applicant, unless good cause exists. If good cause exists, a County shall document the reasons for the delay and generate a timeline for completion.</li> <li>◦ An applicant is not eligible to receive an AFDC-FC or state foster care payment until the applicant is approved as a Resource Family and the child or NAD meets all other eligibility criteria. The temporary placement of a child or NAD with an applicant pursuant to this section does not ensure approval as a Resource Family.</li> </ul>

<sup>1</sup> See WIC 161.402 for information regarding approval of NRHM placement.  
<sup>2</sup> Reference: WIC 59.209(b)(7)(F) and 59A.01.  
<sup>3</sup> A check for prior Domestic Violence and/or sexual offenses conducted by the Administrative Action Records System (AARS) database maintained by the Department, and a check for prior Resource Family-related administrative actions conducted in the Adult and Child Welfare Information System (ACWIS) database maintained by the Department.  
<sup>4</sup> A check for prior Domestic Violence and/or sexual offenses conducted by the Licensing Information System (LIS) database maintained by the Department.  
 Date: November 6, 2023 Page 1

# Emergency Placement vs. Compelling Reason

◦ Begin the RFA process with the applicant which includes submission of the RFA Application and a Comprehensive Assessment of the Family. The Comprehensive Assessment includes the Home Health and Safety Assessment (including the Background Checks) and Permanency Assessment. The Comprehensive Assessment and the Written Report will be completed within 90 calendar days of the date a child or NAD was temporarily placed with the applicant, unless good cause exists. If good cause exists, a County shall document the reasons for the delay and generate a timeline for completion.

◦ An applicant is not eligible to receive an AFDC-FC or an ARC payment until the applicant is approved as a Resource Family and the child or NAD meets all other eligibility criteria. The temporary placement of a child or NAD with an applicant pursuant to this section does not ensure approval as a Resource Family.



# Resource Family Approval

Is it working for you?



# What can attorneys and judges do to make RFA work?

- Take an active oversight role
- Ask where the barriers are. Is the resource parent having trouble getting to classes? Is it a day care issue? Is it a funding issue? What is the problem?
- Set interim hearings to help move the process along.

# Bills to Watch

- Senate Bill 1083 (Mitchell): aims at streamlining parts of the approval process to make it easier on families taking care of children now and prevent a potential exodus of caregivers at the end of 2019.
  - Grandfather in existing caregivers
  - Complete RFA process in 90 days when relative and non-related extended family members are involved
- Failure would prompt a judge to set a hearing.
- Changes WIC to 361.3, 366.31- adds (k)(2)

*(k) (1) If resource family approval is pending, the report shall include an update on the status of the approval, including, but not limited to, which components of the required home environment assessment and permanency assessment have been completed, which components are still pending, and the anticipated date by which the assessments will be completed.*

*(2) If resource family approval has been pending for more than 90 days, the report shall document the reasons for the delay and what efforts have been made by the social worker to address the delay. If the court determines that there is no good cause for the delay, the court may set a hearing within 14 calendar days to review the progress of the approval. The court may also set an order to show cause hearing.*

# Bills to Watch

- Assembly Bill 2183 (Rubio): This bill would:
  - authorize a county to waive the permanency assessment criteria and approve an individual or family as a resource family upon completion of a home environment assessment if exceptional circumstances exist, as specified.
  - require the county to document the reason for the waiver and indicate its applicability to a specific child.
  - require the permanency assessment to be completed as soon as possible and no later than the annual update of the resource family approval.
  - require the county welfare department, immediately following the placement of a child in the home of a relative or nonrelative extended family member who has not been approved as a resource family, to initiate funding through the emergency assistance program that is included in the state's Temporary Assistance for Needy Families block grant for child welfare services or through the Approved Relative Caregiver Funding Program.

# AB 2183

- 361.4: adds
- *(e) (1) Immediately following the placement of a child in the home of a relative or a nonrelative extended family member who has not been approved as a resource family, the county welfare department shall initiate funding through the emergency assistance program that is included in the state's Temporary Assistance for Needy Families block grant for child welfare services or through the Approved Relative Caregiver Funding Program.*
- *(2) Funding initiated at the time of placement may include reasonable travel for the child to remain in the school at which he or she is enrolled at the time of placement.*

# Where to get information:

- CDSS website <http://www.cdss.ca.gov/inforesources/Resource-Family-Approval-Program>
- All county letters and notices: You can subscribe <http://www.cdss.ca.gov/inforesources/Letters-and-Notices>
- Written Directives (v. 5- 2.6.18):  
<http://www.cdss.ca.gov/Portals/9/RFA/Final%20V5%20%202.6.18.pdf?ver=2018-02-06-084609-033>

# Other Challenges for the Court

In CCR implementation

# Where laws collide in CCR implementation

- Timelines for CFTs and Dispositional Hearings
- Legal authority over STRTP placements; what happens if the court wants to continue the placement but the director or chief does not?
- Transition to Successful Adulthood findings versus case plan requirements





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# CliffsNotes on Family First Act, Part One: Services to Prevent Foster Care

by *John Kelly* February 13, 2018  
| *John Kelly*

As *The Chronicle of Social Change* reported in multiple stories last week, the Family First Prevention Services Act **has become law**. It includes the biggest change to the structure of federal child welfare finance since the establishment of the Title IV-E entitlement in 1980.

So what is actually in this thing? *Youth Services Insider* pored over all 103 pages of the law. Here we begin a full, three-part breakdown of its two major sections and all of the additional provisions inside Family First.

## PREVENTION SERVICES



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The central feature of the bill is that states will now be able to use funds derived from Title IV-E of the Social Security Act – the entitlement that pays for child welfare – for “time-limited” services aimed at preventing the use of foster care in maltreatment cases. Currently, IV-E is only allowable for spending on foster care placements and for assistance to adoptive families.



The Family First Act, first drafted by Sens. Orrin Hatch and Ron Wyden, became law in February

### What types of services are we talking about?

There are three areas of services that states can spend this money on:

- Services to address mental health challenges.
- Substance abuse treatment.
- In-home parent skill-based programs.

### Who is eligible for these new services?

There are two groups:

- Parents or relatives caring for children who are “candidates for foster care”
- Youth in foster care who are pregnant or already parents.

### What makes a child a “candidate for foster care?”

A child who would have to enter care but doesn’t “as long as” Family First Act services are made available.

### Does this only apply to birth parents?

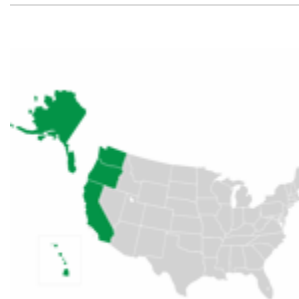
No. The candidate status applies to a child whose adoption or guardianship status would be

## STATELINE

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disrupted or dissolved without these services.

### **So a worker just says, “You’re a candidate for foster care,” and then the tap turns on?**

Not exactly. There needs to be a formal prevention plan in place for foster care candidates, and that includes:

- Identifying a strategy that allows a kid to stay at home, live with a kin caregiver temporarily, or “live permanently” with a kin caregiver.
- A list of services associated with that strategy.

For pregnant teens, a strategy must have a list of services for the youth, and the “foster care prevention” strategy for any child born to them.

The law also invites the Department of Health and Human Services (DHHS) to add further requirements to the prevention plan process, so this could change.

### **What does “time-limited” mean, how long do states have?**

An agency can spend IV-E on prevention services for 12 months. The clock starts the day a child is identified in a “prevention plan” as a candidate for foster care, or when they are listed on a prevention plan as being pregnant or parenting.

### **Can this new program be used for any services that address mental health, substance abuse or parenting challenges?**

No. Any allowable service must check a few boxes off in terms of efficacy.

First, there are general practice requirements. There must be a manual specifying the components of it. The preponderance of outcome measurements for it must suggest a clear benefit, and there can’t be any “case data suggesting a risk of harm that probably was caused by the treatment and that was severe or frequent.”

Second, any services must meet one of the following three thresholds:

*Promising Practice:* “Superior to” a comparable practice using conventional standards of statistical significance. This must be borne out in an independently reviewed study that used “some form of control” group (a placebo group, a waitlist, or a group of untreated people).

*Supported Practice:* Same, but has a random-controlled trial or a “rigorous” quasi-experimental design. Must demonstrate sustained effects for six months beyond end of treatment.

*Well-Supported Practice:* A sustained effect for “at least one year beyond the end of treatment.”

HHS will develop the formal standards for determining which services count under these three classes. The deadline set in Family First for that is October of this year. To get a sense of what the likely programs and models are, though, you can check out the [California Evidence-Based Clearinghouse for Child Welfare](#), which is the template for this section of the law.

Of the 433 programs cataloged in the California child welfare clearinghouse, 210 have achieved one of these three ratings

### **How much is the federal government kicking in?**

Fifty percent from 2019 until 2026. After that, the federal match for time-limited services is pegged to the federal [medical assistance percentage](#).

For most states, this will mean more federal participation, especially in states with the highest concentration of low-income families. But there is a caveat: by 2026, half of state expenditures in this area must go toward “well-supported practices,” the highest ranking of the three classes. Very few services have this status under the California Clearinghouse, so the hope is that this program will help drive the evidence and evaluation of more strategies and models.

### **Do states *have* to provide these services using IV-E funds?**

Nope. The law makes several references to states “electing” to participate. For states that do, though, it must become a component of their overall IV-E state plan.

There is a long list of requirements for this plan, but in a nutshell: states must show in writing that they have a system for choosing, implementing and evaluating the time-limited services, and that caseworkers are trained to administer them.

While Family First money cannot be used to pay for training kinship caregivers or caseworkers, states can get a 50 percent match for training and work related to developing the state plan.

Since process of evaluating these programs is required in the state plan, it appears that the cost of these evaluations will be split 50-50 between the states and the federal government.

**Some or all states are probably already spending money on this right now. Can this money replace that funding?**

They can replace *how* those services were funded before, but not *how much* it was funded.

Under the maintenance of effort rules for Family First, a state must spend on “foster care prevention” what it spent in fiscal year 2014, 2015 or 2016 (whichever is favorable to the state).

The definition of “foster care prevention,” for the purposes of this law, is funds spend on preventing the need for foster care under state or local programs, or under other federal funding streams such as the Social Services Block Grant, Temporary Assistance for Needy Families and Title IV-B of the Social Security Act.

States will have to submit and be able to defend their maintenance of effort baselines against review by HHS.

**There’s an income test under Title IV-E still for foster care maintenance payments. Is that true for the time-limited prevention services?**

Nope. These can be administered in the case of any family where the “foster care candidate” status is valid.

### **Sometimes relatives will need to take a child in while the parents get help. Does Family First provide financial assistance to these relatives?**

It does not. There was assistance written into earlier versions of the law for kin, but as the bill was negotiated and pared down cost-wise, those provisions did not survive. The act does offer to federally match state spending on kinship navigator programs, which are one-stop shops to assist kinship caregivers.

### **So what happens if the time-limited services don't work?**

If the child is staying with relatives, and the prevention services have not succeeded, the likely first preference of the system will be to keep the child with the relative on a longer-term basis. This could occur informally; the relative could become a licensed foster parent or could either adopt the child or enter into a guardianship agreement.

**One concern** some had about Family First is that there is a great fiscal incentive for the state to steer things toward an informal custody arrangement. If the child enters foster care, that will cost money, and so would a guardianship or adoption that followed.

This means that if a parent fails to get to the point where a system is okay returning the child, financial help for the kinship support network of that child is contingent on him or her entering foster care.

Family First does essentially guarantee that if the system places the child in the foster care custody of a relative, the state can draw in federal money to help with those foster care payments, as long as the birth parent's income would have originally qualified the child for federal reimbursement.

### **What about programs that allow a child to live with a parent while they get residential**

## **treatment for substance abuse?**

If a child is reimbursable under the IV-E foster care income tests, then a state can seek IV-E reimbursement for a child placed in such a facility. There must be a formal recommendation made for the placement, presumably by a judge, and the facility must provide parenting and counseling sessions, in addition to rehab.

## **Is the federal government going to help states gear up for this?**

Two avenues on that front. First, the law instructs HHS to “provide technical assistance” and disseminate best practices, including on how to do a rigorous evaluation of time-limited services.

Second, either housed at or paid for by HHS, there will be a clearinghouse to evaluate and highlight the data and outcomes associated with services in this space. This will include at the very least information on if a program has been shown to reduce maltreatment, and if it has reduced the likelihood of foster care placement.

HHS will also be on the hook to report to the committees with jurisdiction on Family First: The Senate Finance Committee and House Ways and Means. This requirement includes the nebulous “periodic reports” caveat. Whenever those reports come out, they will be public.

## **When does all this start?**

A: The new funding kicks in in October of 2019. Plans for HHS to develop technical assistance and a clearinghouse are effective already, with the earliest deadlines for rule making coming in October of 2018.

*Note: This story was updated on Wednesday, Feb. 15.*

***If you are interested in federal juvenile justice and child welfare policy, read our special issue “Kids on the Hill.” [Just hit this LINK.](#)***

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— *John Kelly*

*John Kelly is senior editor for The Chronicle of Social Change.*

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It is not just that FFPSA "does not help" relatives care for children. More than that, it sets up an incentive for states not to help because if the relative becomes a foster parent, the child is not a "candidate for foster care" and therefore the parent can't get IVE-funded services. So it sets up a choice: help the relative and the child vs. help the parent.

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# CliffsNotes on Family First Act, Part Two: Limiting Support for Congregate Foster Care

by *John Kelly* February 14, 2018  
| *John Kelly*

As *The Chronicle of Social Change* reported in multiple stories last week, the Family First Prevention Services Act **has become law**. It includes the biggest change to the structure of federal child welfare finance since the establishment of the Title IV-E entitlement in 1980.

So what is actually in this thing? *Youth Services Insider* pored over all 103 pages of the law. Here is part two of our three-part breakdown of its two major sections and all of the additional provisions inside Family First.

## LIMITING CONGREGATE CARE



If a child is placed by an agency into a “child care institution,” no IV-E foster care payment can be made beginning with the third week of that placement. States can still seek reimbursement for the administrative expenditures related to a child’s case though.

### What is a “child care institution?”

The law basically defines a “family foster home” as having six or fewer kids, with some notable exceptions made to keep siblings together and a few other reasons.

A “child care institution” includes any private child-serving institution, and any public child-serving institution that holds 25 or fewer children. Federal law already precludes IV-E reimbursement for placements larger than that.

One important carve-out here is that the law exempts from this juvenile facilities involved in pre- or post-adjudication services. On the flipside, though, the law requires the state not to “enact or advance policies” that would increase the population of the juvenile justice system.

Translation: No arresting youth for the purpose of being able to house them in group settings. The law also mandates a Government Accountability Office (GAO) study on the matter, due by the year 2025.



The Family First Act, first drafted by Sens. Orrin Hatch and Ron Wyden, became law this month

**So the federal government won’t pay for congregate care after two weeks under any circumstances?**

## STATELINE

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Not exactly. There are several very significant exceptions to this new rule. The following placements would be eligible for payments beyond two weeks:

- A setting for prenatal, postpartum or parenting supports for teen moms.
- A supervised setting for a child 18 or older. This allows states to continue to receive support for extended foster care, a key provision of Fostering Connections to Success and Increasing Adoptions Act that about half the states have opted into.
- “High quality residential services” for youth who have been victims of trafficking or who are at risk of it. It will be of interest how HHS further regulates this in regard to the terms “high quality” and “at risk.”
- A “qualified residential treatment program,” or QRTP.

### **Yet another acronym is born! What is QRTP?**

The law identifies several defining characteristics of such a setting:

- Licensed by at least one of three accreditors: Commission on Accreditation of Rehabilitation Facilities; Joint Commission on Accreditation of Healthcare Organizations; Council on Accreditation.
- Has a trauma-informed treatment model that includes service of clinical needs.
- Has registered or licensed nursing staff in accordance with the model, and that a nurse is on call at all times. Note: The original bill actually required a nurse or clinical staff on premises during all work/operating hours and on call at night.
- Is inclusive of family members in treatment plans and programs.
- Plans for at least a six-month window of support after discharge.

### **Can a state use a QRTP for the long haul with kids?**

Theoretically yes, but not without a review process. There is a 30-day window for an assessment that deems the placement necessary. After that, assessment of the continued need for the placement must be conducted every 60 days.

For really long-term stays – 12 months straight, or any 18 months – the actual head of the state agency must sign off.

The law also requires state IV-E plans to demonstrate “procedures and protocols” to ensure that foster youth are not inappropriately given mental health diagnoses that would make it easier to justify their placement in a QRTP.

HHS will have to do an evaluation by 2020 to determine best practices and trends on this subject.

### **How long do states have until these limits take effect?**

It could take until 2021 for these limits in some states.

The limitations on group care do not take effect for anyone until October 2019. But states can also apply to get a two-year delay on these limits. There is a caveat though: if a state delays on the congregate care limits, it precludes any reimbursement for the front-end prevention services provided in the law.

Surely, the authors intended that caveat to serve as an incentive against states seeking a delay on congregate care. But it’s worth noting that the opposite might occur: states that might have embraced the front-end cost-sharing, but are wary of the congregate impact, might forgo the foster care prevention funds to lock in a delay.

The delay decision ability gives significant power to state agencies in states where the county child welfare agencies do a lot of the work. For example: In Pennsylvania, if Allegheny County really wants to tap into those front-end federal funds, it is out of luck for a while if Pennsylvania decides to seek a delay on congregate care.

Or in California, let's say Los Angeles really does not want the congregate care limits. If the state decides *not* to seek a delay, those limitations are coming a year or two sooner than the county wants.

***If you are interested in federal juvenile justice and child welfare policy, read our special issue "Kids on the Hill." [Just hit this LINK.](#)***

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— ***John Kelly***

*John Kelly is senior editor for The Chronicle of Social Change.*

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# CliffsNotes on Family First Act, Part Three: Adoption, Foster Home Recruitment, Reunification and More

by *John Kelly* February 15, 2018  
| *John Kelly*

As *The Chronicle of Social Change* reported in multiple stories last week, the Family First Prevention Services Act **has become law**. It includes the biggest change to the structure of federal child welfare finance since the establishment of the Title IV-E entitlement in 1980.

So what is actually in this thing? *Youth Services Insider* pored over all 103 pages of the law. Here is part three of our three-part breakdown of its two major sections and all of the additional provisions inside Family First.



## EVERYTHING ELSE

The foster care prevention services and the limits on congregate care are the central reasons for this legislation. But there are several significant provisions that are included in the bill that became law.

**Adoption Assistance:** The law pays for the projected spending on foster care prevention services with definite cuts to spending on adoption assistance.

Federal adoption assistance payments under Title IV-E used to be pegged to income tests in the same way as the IV-E foster care payments. So only children adopted from parents who were very poor carried a federal contribution; states had to provide the full subsidy for other children.



The Family First Act, first drafted by Sens. Orrin Hatch (R-Utah) and Ron Wyden (D-Ore.), became law this month.

The Fostering Connections to Success and Increasing Adoptions Act, signed in 2008, set that income test to gradually expire by 2019. It began with de-linking the income test for teens (a low percentage of the youth adopted from care) and worked backward to newborns and babies (the biggest portion of adoptees). The caveat was that states needed to spend the savings they reaped on helping adoptive families.

This law freezes the de-link at 2-year-olds and delays it until the year 2024. In the meantime, the GAO will conduct a study to determine if states are using the money they save from the adoption de-link to serve adoptive families.

### STATELINE

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### Oklahoma Senate Could Vote on Faith-Based Protection Bill Today

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**Adoption and Guardianship Incentives:** In 2014, the Preventing Sex Trafficking and Strengthening Families Act reworked the federal adoption incentives program which rewards states for finalizing the adoptions of youth in foster care. That **law shifted the program** to include guardianships, place more emphasis on the adoption of older youth in foster care, and pegged the incentive calculations to more recent data.

The Family First simply extends the incentive program to 2021.

**Reunification:** As Family First adds time-limited services under IV-E, it takes away time limits on services under the “reunification” section of Promoting Safe and Stable Families (Title IV-B), the block grant for family preservation.

There is a 15-month limit on the funds once a child enters foster care; that’s gone, now there is no limit on how long services can be provided during that stay. And now, the funds can also be used to continue supports for 15 months after the child returns home.

It is unlikely to happen, but Promoting Safe and Stable Families **would be vulnerable to any sequestration** that’s prompted by the tax cut package that President Trump signed into law.

**Kinship Navigator Programs:** Currently, the federal government makes \$15 million in grants per year for “kinship navigator” programs under the Family Connections grants program, which was established by the Fostering Connections to Success and Increasing Adoptions Act. These programs serve as one-stop centers for assistance to relatives who are caring for children.

The Family First Act offers an additional 50 percent match on any funds spent by a state for a kinship navigator program that has earned the promising/supported/well-supported status.

**Cross-State Placements:** By the year 2027, all states must move to an “electronic interstate case-processing system.” A \$5 million pot of money is

available from 2018 to 2022 for states to apply to get assistance developing such a system.

This emanates from bills in both chambers called the Modernizing the Interstate Placement of Children in Foster Care Act.

**Foster Home Licensing:** By October 2018, HHS must have model licensing standards for foster family homes.

- States will have to certify if its licensing is in accord with the model and explain why not.
- Acknowledge if states have waived some standards for relatives.

If HHS is looking for inspiration, it might look into the [National Model Family Foster Home Licensing Standards](#), a document put together in 2014 by the American Bar Association, Generations United and the National Association for Regulatory Administration.

### **Foster Home Recruitment and**

**Retention:** Section 431 of the Social Security Act lays out the federal definitions of “family preservation services” and “family support services.” In both cases, most but not all of the defined options pertain to assisting birth families.

Family support services do include the strengthening of families, including foster and adoptive ones. The Family First Act adds the “support and retention” of foster families as a newly defined service. The bill also appears to free up a very small pot, \$8 million available through 2022, for recruitment and retention efforts.

This fall, *The Chronicle of Social Change* [produced a report](#) finding that at least half of states had either lost foster home capacity, or had seen any gains outpaced by a rising number of youth in care. While some states have had [recent success recruiting new homes](#), many others are struggling to move the needle despite [dedicated efforts to do so](#).

This is the issue that fits squarely in between the two major gambits of the Family First Act. If the

front-end services succeed, that will lower the number of youth coming into foster care. And that will be necessary, because if the congregate care limitations work in reducing the use of such placements, those youth would presumably end up in foster homes.

**Plan for Prevention of Maltreatment Deaths:**

Each state would be required to provide two things: A description of the steps the state is taking to compile complete and accurate information on maltreatment-related deaths, and a description of steps that the state is taking to implement a “plan to prevent the fatalities.”

This notion was promulgated as part of the recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities, which [produced its final report](#) in 2016, and was [included in Senate legislation](#) introduced this fall after the Finance Committee [concluded an investigation](#) into foster care privatization.

**Chafee Independent Living:** The Chafee program offers \$140 million each year for states to offer independent living programs to youth who are aging out of foster care into adulthood.

The eligibility threshold for participants is 21. For states that have extended foster care to include 18- to 21-year-olds – Ohio [recently became the 25th](#) state on that list – they can now extend eligibility through age 23.

**Chafee Education Training Vouchers (ETV):** This program provides \$45 million per year to states to assist youth aging out of care with college costs. The current age ceiling is 23, and Family First raises that to 26, with the rider that no single student can get a voucher for more than five years.

This proposal was originally part of the bill back in 2014 that changed the adoption incentive program, but did not make the final version. [As we wrote back then](#), there is some downside to this shift since it appears to come without any increase in funding.

Without a proportional increase in funds for ETV, the expansion implicitly instructs states to spread the funds over a larger number of students; perhaps thousands more in highly populous states. Not all states spend their entire ETV allotment, but many do. In California, there is routinely a wait-list for ETV grants already, and the state’s process favored current recipients over new applicants.

When this idea was first floated, California advocates told *Youth Services Insider* that it could cause real problems without more money.

“If this does go into effect and a state like [California] continues to implement ETV along their current lines, we’ll have even less freshmen and sophomores receiving funding,” said Serita Cox, co-founder of iFoster, in a 2013 conversation with *YSI*. “And I would argue that if we want to meaningfully move the needle on those earning their bachelor’s degree, having funds for those freshmen and sophomores is more important than a 26-year-old on their graduate degree.”

***If you are interested in federal juvenile justice and child welfare policy, read our special issue “Kids on the Hill.” Just hit this LINK.***

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— **John Kelly**



*John Kelly is senior editor for The Chronicle of Social Change.*

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## H.R.253 - Family First Prevention Services Act of 2017

115th Congress (2017-2018) | [Get alerts](#)

**Sponsor:** [Rep. Buchanan, Vern \[R-FL-16\]](#) (Introduced 01/04/2017)

**Committees:** House - Ways and Means

**Latest Action:** House - 01/13/2017 Referred to the Subcommittee on Human Resources. ([All Actions](#))

**Tracker:** **Introduced** Passed House Passed Senate To President Became Law

### Text: H.R.253 — 115th Congress (2017-2018)

[All Information](#) (Except Text)

There is one version of the bill.

**Text available as:** XML/HTML | [XML/HTML \(new window\)](#) | [TXT](#) | [PDF](#) (PDF provides a complete and accurate display of this text.) ?

**Shown Here:**  
**Introduced in House (01/04/2017)**

115TH CONGRESS  
1ST SESSION

# H. R. 253

To amend parts B and E of title IV of the Social Security Act to invest in funding prevention and family services to help keep children safe and supported at home, to ensure that children in foster care are placed in the least restrictive, most family-like, and appropriate settings, and for other purposes.

## IN THE HOUSE OF REPRESENTATIVES

JANUARY 4, 2017

Mr. BUCHANAN (for himself and Mr. LEVIN) introduced the following bill; which was referred to the Committee on Ways and Means

# A BILL

To amend parts B and E of title IV of the Social Security Act to invest in funding prevention and family services to help keep children safe and supported at home, to ensure that children in foster care are placed in the least restrictive, most family-like, and appropriate settings, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## **SECTION 1. SHORT TITLE.**

This Act may be cited as the “Family First Prevention Services Act of 2017”.

## **SEC. 2. TABLE OF CONTENTS.**

The table of contents for this Act is as follows:

[Sec. 1. Short title.](#)

[Sec. 2. Table of contents.](#)

### TITLE I—INVESTING IN PREVENTION AND FAMILY SERVICES

[Sec. 101. Purpose.](#)

#### Subtitle A—Prevention Activities Under Title IV–E

[Sec. 111. Foster care prevention services and programs.](#)

[Sec. 112. Foster care maintenance payments for children with parents in a licensed residential family-based treatment facility for substance abuse.](#)

[Sec. 113. Title IV–E payments for evidence-based kinship navigator programs.](#)

#### Subtitle B—Enhanced Support Under Title IV–B

[Sec. 121. Elimination of time limit for family reunification services while in foster care and permitting time-limited family reunification services when a child returns home from foster care.](#)

[Sec. 122. Reducing bureaucracy and unnecessary delays when placing children in homes across State lines.](#)

[Sec. 123. Enhancements to grants to improve well-being of families affected by substance abuse.](#)

#### Subtitle C—Miscellaneous

[Sec. 131. Reviewing and improving licensing standards for placement in a relative foster family home.](#)

[Sec. 132. Development of a statewide plan to prevent child abuse and neglect fatalities.](#)

[Sec. 133. Modernizing the title and purpose of title IV–E.](#)

[Sec. 134. Effective dates.](#)

### TITLE II—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME

[Sec. 201. Limitation on Federal financial participation for placements that are not in foster family homes.](#)

[Sec. 202. Assessment and documentation of the need for placement in a qualified residential treatment program.](#)

[Sec. 203. Protocols to prevent inappropriate diagnoses.](#)

[Sec. 204. Additional data and reports regarding children placed in a setting that is not a foster family home.](#)

[Sec. 205. Effective dates; application to waivers.](#)

### TITLE III—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES

[Sec. 301. Supporting and retaining foster families for children.](#)

[Sec. 302. Extension of child and family services programs.](#)

[Sec. 303. Improvements to the John H. Chafee foster care independence program and related provisions.](#)

### TITLE IV—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP

[Sec. 401. Reauthorizing adoption and legal guardianship incentive programs.](#)

### TITLE V—TECHNICAL CORRECTIONS

[Sec. 501. Technical corrections to data exchange standards to improve program coordination.](#)

[Sec. 502. Technical corrections to State requirement to address the developmental needs of young children.](#)

### TITLE VI—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE

[Sec. 601. Delay of adoption assistance phase-in.](#)

[Sec. 602. GAO study and report on State reinvestment of savings resulting from increase in adoption assistance.](#)

## TITLE I—INVESTING IN PREVENTION AND FAMILY SERVICES

### **SEC. 101. PURPOSE.**

The purpose of this title is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services.

### Subtitle A—Prevention Activities Under Title IV–E

### **SEC. 111. FOSTER CARE PREVENTION SERVICES AND PROGRAMS.**

(a) STATE OPTION.—Section 471 of the Social Security Act ([42 U.S.C. 671](#)) is amended—

(1) in subsection (a)(1), by striking “and” and all that follows through the semicolon and inserting “, adoption assistance in accordance with section 473, and, at the option of the State, services or programs specified in subsection (e)(1) of this section for children who are candidates for foster care or who are pregnant or parenting foster youth and the parents or kin caregivers of the children, in accordance with the requirements of that subsection;”; and

(2) by adding at the end the following:

“(e) PREVENTION AND FAMILY SERVICES AND PROGRAMS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary may make a payment to a State for providing the following services or programs for a child described in paragraph (2) and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:

“(A) MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child.

“(B) IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.

“(2) CHILD DESCRIBED.—For purposes of paragraph (1), a child described in this paragraph is the following:

“(A) A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1).

“(B) A child in foster care who is a pregnant or parenting foster youth.

“(3) DATE DESCRIBED.—For purposes of paragraph (1), the dates described in this paragraph are the following:

“(A) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a child who is a candidate for foster care (as defined in section 475(13)).

“(B) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a pregnant or parenting foster youth in need of services or programs specified in paragraph (1).

“(4) REQUIREMENTS RELATED TO PROVIDING SERVICES AND PROGRAMS.—Services and programs specified in paragraph (1) may be provided under this subsection only if specified in advance in the child’s prevention plan described in subparagraph (A) and the requirements in subparagraphs (B) through (E) are met:

“(A) PREVENTION PLAN.—The State maintains a written prevention plan for the child that meets the following requirements (as applicable):

“(i) CANDIDATES.—In the case of a child who is a candidate for foster care described in paragraph (2)(A), the prevention plan shall—

“(I) identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;

“(II) list the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and

“(III) comply with such other requirements as the Secretary shall establish.

“(ii) PREGNANT OR PARENTING FOSTER YOUTH.—In the case of a child who is a pregnant or parenting foster youth described in paragraph (2)(B), the prevention plan shall—

“(I) be included in the child's case plan required under section 475(1);

“(II) list the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent;

“(III) describe the foster care prevention strategy for any child born to the youth; and

“(IV) comply with such other requirements as the Secretary shall establish.

“(B) TRAUMA-INFORMED.—The services or programs to be provided to or on behalf of a child are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma’s consequences and facilitate healing.

“(C) ONLY SERVICES AND PROGRAMS PROVIDED IN ACCORDANCE WITH PROMISING, SUPPORTED, OR WELL-SUPPORTED PRACTICES PERMITTED.—

“(i) IN GENERAL.—Only State expenditures for services or programs specified in subparagraph (A) or (B) of paragraph (1) that are provided in accordance with practices that meet the requirements specified in clause (ii) of this subparagraph and that meet the requirements specified in clause (iii), (iv), or (v), respectively, for being a promising, supported, or well-supported practice, shall be eligible for a Federal matching payment under section 474(a)(6)(A).

“(ii) GENERAL PRACTICE REQUIREMENTS.—The general practice requirements specified in this clause are the following:

“(I) The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.

“(II) There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

“(III) If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.

“(IV) Outcome measures are reliable and valid, and are administrated consistently and accurately across all those receiving the practice.

“(V) There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

“(iii) PROMISING PRACTICE.—A practice shall be considered to be a ‘promising practice’ if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

“(I) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; and

“(II) utilized some form of control (such as an untreated group, a placebo group, or a wait list study).

“(iv) SUPPORTED PRACTICE.—A practice shall be considered to be a ‘supported practice’ if—

“(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

“(aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

“(bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and

“(cc) was carried out in a usual care or practice setting; and

“(II) the study described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

“(v) WELL-SUPPORTED PRACTICE.—A practice shall be considered to be a ‘well-supported practice’ if—

“(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that—

“(aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

“(bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and

“(cc) were carried out in a usual care or practice setting; and

“(II) at least one of the studies described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment.



“(D) GUIDANCE ON PRACTICES CRITERIA AND PRE-APPROVED SERVICES AND PROGRAMS.—

“(i) IN GENERAL.—Not later than October 1, 2018, the Secretary shall issue guidance to States regarding the practices criteria required for services or programs to satisfy the requirements of subparagraph (C). The guidance shall include a pre-approved list of services and programs that satisfy the requirements.

“(ii) UPDATES.—The Secretary shall issue updates to the guidance required by clause (i) as often as the Secretary determines necessary.

“(E) OUTCOME ASSESSMENT AND REPORTING.—The State shall collect and report to the Secretary the following information with respect to each child for whom, or on whose behalf mental health and substance abuse prevention and treatment services or in-home parent skill-based programs are provided during a 12-month period beginning on the date the child is determined by the State to be a child described in paragraph (2):

“(i) The specific services or programs provided and the total expenditures for each of the services or programs.

“(ii) The duration of the services or programs provided.

“(iii) In the case of a child described in paragraph (2)(A), the child’s placement status at the beginning, and at the end, of the 1-year period, respectively, and whether the child entered foster care within 2 years after being determined a candidate for foster care.

“(5) STATE PLAN COMPONENT.—

“(A) IN GENERAL.—A State electing to provide services or programs specified in paragraph (1) shall submit as part of the State plan required by subsection (a) a prevention services and programs plan component that meets the requirements of subparagraph (B).

“(B) PREVENTION SERVICES AND PROGRAMS PLAN COMPONENT.—In order to meet the requirements of this subparagraph, a prevention services and programs plan component, with respect to each 5-year period for which the plan component is in operation in the State, shall include the following:

“(i) How providing services and programs specified in paragraph (1) is expected to improve specific outcomes for children and families.

“(ii) How the State will monitor and oversee the safety of children who receive services and programs specified in paragraph (1), including through periodic risk assessments throughout the period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph (4) for the provision of the services or programs if the State determines the risk of the child entering foster care remains high despite the provision of the services or programs.

“(iii) With respect to the services and programs specified in subparagraphs (A) and (B) of paragraph (1), information on the specific promising, supported, or well-supported practices the State plans to use to provide the services or programs, including a description of—

“(I) the services or programs and whether the practices used are promising, supported, or well-supported;

“(II) how the State plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;

“(III) how the State selected the services or programs;

“(IV) the target population for the services or programs; and

“(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary.

“(iv) A description of the consultation that the State agencies responsible for administering the State plans under this part and part B engage in with other State agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph (2) and their parents or kin caregivers.

“(v) A description of how the State shall assess children and their parents or kin caregivers to determine eligibility for services or programs specified in paragraph (1).

“(vi) A description of how the services or programs specified in paragraph (1) that are provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the State plan under part B.

“(vii) Descriptions of steps the State is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—

“(I) ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and

“(II) developing appropriate prevention plans, and conducting the risk assessments required under clause (iii).

“(viii) A description of how the State will provide training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to

access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.

“(ix) A description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen.

“(x) An assurance that the State will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph (1), including information and data necessary to determine the performance measures for the State under paragraph (6) and compliance with paragraph (7).

“(C) REIMBURSEMENT FOR SERVICES UNDER THE PREVENTION PLAN COMPONENT.

“(i) LIMITATION.—Except as provided in subclause (ii), a State may not receive a Federal payment under this part for a given promising, supported, or well-supported practice unless (in accordance with subparagraph (B)(iii)(V)) the plan includes a well-designed and rigorous evaluation strategy for that practice.

“(ii) WAIVER OF LIMITATION.—The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice.

“(6) PREVENTION SERVICES MEASURES.—

“(A) ESTABLISHMENT; ANNUAL UPDATES.—Beginning with fiscal year 2021, and annually thereafter, the Secretary shall establish the following prevention services measures based on information and data reported by States that elect to provide services and programs specified in paragraph (1):

“(i) PERCENTAGE OF CANDIDATES FOR FOSTER CARE WHO DO NOT ENTER FOSTER CARE.—The percentage of candidates for foster care for whom, or on whose behalf, the services or programs are provided who do not enter foster care, including those placed with a kin caregiver outside of foster care, during the 12-month period in which the services or programs are provided and through the end of the succeeding 12-month period.

“(ii) PER-CHILD SPENDING.—The total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skill-based programs, respectively, for, or on behalf of, each child described in paragraph (2).

“(B) DATA.—The Secretary shall establish and annually update the prevention services measures—

“(i) based on the median State values of the information reported under each clause of subparagraph (A) for the 3 then most recent years; and

“(ii) taking into account State differences in the price levels of consumption goods and services using the most recent regional price parities published by the Bureau of Economic Analysis of the Department of Commerce or such other data as the Secretary determines appropriate.

“(C) PUBLICATION OF STATE PREVENTION SERVICES MEASURES.—The Secretary shall annually make available to the public the prevention services measures of each State.

“(7) MAINTENANCE OF EFFORT FOR STATE FOSTER CARE PREVENTION EXPENDITURES.

“(A) IN GENERAL.—If a State elects to provide services and programs specified in paragraph (1) for a fiscal year, the State foster care prevention expenditures for the fiscal year shall not be less than the amount of the expenditures for fiscal year 2014.

“(B) STATE FOSTER CARE PREVENTION EXPENDITURES.—The term ‘State foster care prevention expenditures’ means the following:

“(i) TANF; IV–B; SSBG.—State expenditures for foster care prevention services and activities under the State program funded under part A (including from amounts made available by the Federal Government), under the State plan developed under part B (including any such amounts), or under the Social Services Block Grant Programs under subtitle A of title XX (including any such amounts).

“(ii) OTHER STATE PROGRAMS.—State expenditures for foster care prevention services and activities under any State program that is not described in clause (i) (other than any State expenditures for foster care prevention services and activities under the State program under this part (including under a waiver of the program)).

“(C) STATE EXPENDITURES.—The term ‘State expenditures’ means all State or local funds that are expended by the State or a local agency including State or local funds that are matched or reimbursed by the Federal Government and State or local funds that are not matched or reimbursed by the Federal Government.

“(D) DETERMINATION OF PREVENTION SERVICES AND ACTIVITIES.—The Secretary shall require each State that elects to provide services and programs specified in paragraph (1) to report the expenditures specified in subparagraph (B) for fiscal year 2014 and for such fiscal years thereafter as are necessary to determine whether the State is complying with the maintenance of effort requirement in subparagraph (A). The Secretary shall specify the specific services and activities under each program referred to in subparagraph (B) that are ‘prevention services and activities’ for purposes of the reports.

“(8) PROHIBITION AGAINST USE OF STATE FOSTER CARE PREVENTION EXPENDITURES AND FEDERAL IV–E PREVENTION FUNDS FOR MATCHING OR EXPENDITURE REQUIREMENT.—A State that elects to provide services and programs specified in paragraph (1) shall not use any State foster care prevention expenditures for a fiscal year for the State share of expenditures under section 474(a)(6) for a fiscal year.

“(9) ADMINISTRATIVE COSTS.—Expenditures described in section 474(a)(6)(B)—

“(A) shall not be eligible for payment under subparagraph (A), (B), or (E) of section 474(a)(3); and

“(B) shall be eligible for payment under section 474(a)(6)(B) without regard to whether the expenditures are incurred on behalf of a child who is, or is potentially, eligible for foster care maintenance payments under this part.

“(10) APPLICATION.—The provision of services or programs under this subsection to or on behalf of a child described in paragraph (2) shall not be considered to be receipt of aid or assistance under the State plan under this part for purposes of eligibility for any other program established under this Act.”.

(b) DEFINITION.—Section 475 of such Act ([42 U.S.C. 675](#)) is amended by adding at the end the following:

“(13) The term ‘child who is a candidate for foster care’ means, a child who is identified in a prevention plan under section 471(e)(4)(A) as being at imminent risk of entering foster care (without regard to whether the child would be eligible for foster care maintenance payments under section 472 or is or would be eligible for adoption assistance or kinship guardianship assistance payments under section 473) but who can remain safely in the child's home or in a kinship placement as long as services or programs specified in section 471(e)(1) that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.”.

(c) PAYMENTS UNDER TITLE IV–E.—Section 474(a) of such Act ([42 U.S.C. 674\(a\)](#)) is amended—

(1) in paragraph (5), by striking the period at the end and inserting “; plus”; and

(2) by adding at the end the following:

“(6) subject to section 471(e)—

“(A) for each quarter—

“(i) subject to clause (ii)—

“(I) beginning after September 30, 2019, and before October 1, 2025, an amount equal to 50 percent of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C); and

“(II) beginning after September 30, 2025, an amount equal to the Federal medical assistance percentage (which shall be as defined in section 1905(b), in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the

practices in section 471(e)(4)(C) (or, with respect to the payments made during the quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 479B(d) (in this paragraph referred to as the ‘tribal FMAP’) if the Indian tribe, tribal organization, or tribal consortium made the payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State); except that

“(ii) not less than 50 percent of the total amount payable to a State under clause (i) for a fiscal year shall be for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with well-supported practices; plus

“(B) for each quarter specified in subparagraph (A), an amount equal to the sum of the following proportions of the total amount expended during the quarter:

“(i) 50 percent of so much of the expenditures as are found necessary by the Secretary for the proper and efficient administration of the State plan for the provision of services or programs specified in section 471(e)(1), including expenditures for activities approved by the Secretary that promote the development of necessary processes and procedures to establish and implement the provision of the services and programs for individuals who are eligible for the services and programs and expenditures attributable to data collection and reporting; and

“(ii) 50 percent of so much of the expenditures with respect to the provision of services and programs specified in section 471(e)(1) as are for training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision and of the members of the staff of State-licensed or State-approved child welfare agencies providing services to children described in section 471(e)(2) and their parents or kin caregivers, including on how to determine who are individuals eligible for the services or programs, how to identify and provide appropriate services and programs, and how to oversee and evaluate the ongoing appropriateness of the services and programs.”.

(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, AND DATA COLLECTION AND EVALUATIONS.—Section 476 of such Act ([42 U.S.C. 676](#)) is amended by adding at the end the following:

“(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, DATA COLLECTION, AND EVALUATIONS RELATING TO PREVENTION SERVICES AND PROGRAMS.—

“(1) TECHNICAL ASSISTANCE AND BEST PRACTICES.—The Secretary shall provide to States and, as applicable, to Indian tribes, tribal organizations, and tribal consortia, technical assistance regarding the provision of services and programs described in section 471(e)(1) and shall disseminate best practices with respect to the provision of the services and programs, including how to plan and implement a well-designed and rigorous evaluation of a promising, supported, or well-supported practice.

“(2) CLEARINGHOUSE OF PROMISING, SUPPORTED, AND WELL-SUPPORTED PRACTICES.—The Secretary shall, directly or through grants, contracts, or interagency agreements, evaluate research on

the practices specified in clauses (iii), (iv), and (v), respectively, of section 471(e)(4)(C), and programs that meet the requirements described in section 427(a)(1), including culturally specific, or location- or population-based adaptations of the practices, to identify and establish a public clearinghouse of the practices that satisfy each category described by such clauses. In addition, the clearinghouse shall include information on the specific outcomes associated with each practice, including whether the practice has been shown to prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.

“(3) DATA COLLECTION AND EVALUATIONS.—The Secretary, directly or through grants, contracts, or interagency agreements, may collect data and conduct evaluations with respect to the provision of services and programs described in section 471(e)(1) for purposes of assessing the extent to which the provision of the services and programs—

“(A) reduces the likelihood of foster care placement;

“(B) increases use of kinship care arrangements; or

“(C) improves child well-being.

“(4) REPORTS TO CONGRESS.—

“(A) IN GENERAL.—The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives periodic reports based on the provision of services and programs described in section 471(e)(1) and the activities carried out under this subsection.

“(B) PUBLIC AVAILABILITY.—The Secretary shall make the reports to Congress submitted under this paragraph publicly available.

“(5) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary \$1,000,000 for fiscal year 2017 and each fiscal year thereafter to carry out this subsection.”.

(e) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—

(1) IN GENERAL.—Section 479B of such Act ([42 U.S.C. 679c](#)) is amended—

(A) in subsection (c)(1)—

(i) in subparagraph (C)(i)—

(I) in subclause (II), by striking “and” after the semicolon;

(II) in subclause (III), by striking the period at the end and inserting “; and”; and

(III) by adding at the end the following:

“(IV) at the option of the tribe, organization, or consortium, services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers, in accordance with section 471(e) and subparagraph (E).”; and

(ii) by adding at the end the following:

“(E) PREVENTION SERVICES AND PROGRAMS FOR CHILDREN AND THEIR PARENTS AND KIN CAREGIVERS.—

“(i) IN GENERAL.—In the case of a tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers under the plan, the Secretary shall specify the requirements applicable to the provision of the services and programs. The requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to States under section 471(e) and shall permit the provision of the services and programs in the form of services and programs that are adapted to the culture and context of the tribal communities served.

“(ii) PERFORMANCE MEASURES.—The Secretary shall establish specific performance measures for each tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1). The performance measures shall, to the greatest extent practicable, be consistent with the prevention services measures required for States under section 471(e)(6) but shall allow for consideration of factors unique to the provision of the services by tribes, organizations, or consortia.”; and

(B) in subsection (d)(1), by striking “and (5)” and inserting “(5), and (6)(A)”.

(2) CONFORMING AMENDMENT.—The heading for subsection (d) of section 479B of such Act ([42 U.S.C. 679c](#)) is amended by striking “FOR FOSTER CARE MAINTENANCE AND ADOPTION ASSISTANCE PAYMENTS”.

**SEC. 112. FOSTER CARE MAINTENANCE PAYMENTS FOR CHILDREN WITH PARENTS IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.**

(a) IN GENERAL.—Section 472 of the Social Security Act ([42 U.S.C. 672](#)) is amended—

(1) in subsection (a)(2)(C), by striking “or” and inserting “, with a parent residing in a licensed residential family-based treatment facility, but only to the extent permitted under subsection (j), or in a ”; and

(2) by adding at the end the following:

“(j) CHILDREN PLACED WITH A PARENT RESIDING IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.—

“(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, a child who is eligible for foster care maintenance payments under this section, or who would be eligible for the payments if the eligibility were determined without regard to paragraphs (1)(B) and (3) of subsection (a), shall be eligible for



the payments for a period of not more than 12 months during which the child is placed with a parent who is in a licensed residential family-based treatment facility for substance abuse, but only if—

“(A) the recommendation for the placement is specified in the child's case plan before the placement;

“(B) the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and

“(C) the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

“(2) APPLICATION.—With respect to children for whom foster care maintenance payments are made under paragraph (1), only the children who satisfy the requirements of paragraphs (1)(B) and (3) of subsection (a) shall be considered to be children with respect to whom foster care maintenance payments are made under this section for purposes of subsection (h) or section 473(b)(3)(B).”.

(b) CONFORMING AMENDMENT.—Section 474(a)(1) of such Act ([42 U.S.C. 674\(a\)\(1\)](#)) is amended by inserting “subject to section 472(j),” before “an amount equal to the Federal” the first place it appears.

### **SEC. 113. TITLE IV–E PAYMENTS FOR EVIDENCE-BASED KINSHIP NAVIGATOR PROGRAMS.**

Section 474(a) of the Social Security Act ([42 U.S.C. 674\(a\)](#)), as amended by section 111(c), is amended—

(1) in paragraph (6), by striking the period at the end and inserting “; plus”; and

(2) by adding at the end the following:

“(7) an amount equal to 50 percent of the amounts expended by the State during the quarter as the Secretary determines are for kinship navigator programs that meet the requirements described in section 427(a)(1) and that the Secretary determines are operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C), without regard to whether the expenditures are incurred on behalf of children who are, or are potentially, eligible for foster care maintenance payments under this part.”.

## **Subtitle B—Enhanced Support Under Title IV–B**

### **SEC. 121. ELIMINATION OF TIME LIMIT FOR FAMILY REUNIFICATION SERVICES WHILE IN FOSTER CARE AND PERMITTING TIME-LIMITED FAMILY REUNIFICATION SERVICES WHEN A CHILD RETURNS HOME FROM FOSTER CARE.**

(a) IN GENERAL.—Section 431(a)(7) of the Social Security Act ([42 U.S.C. 629a\(a\)\(7\)](#)) is amended—

(1) in the paragraph heading, by striking “TIME-LIMITED FAMILY” and inserting “FAMILY”; and

(2) in subparagraph (A)—

(A) by striking “time-limited family” and inserting “family”;

(B) by inserting “or a child who has been returned home” after “child care institution”; and

(C) by striking “, but only during the 15-month period that begins on the date that the child, pursuant to section 475(5)(F), is considered to have entered foster care” and inserting “and to ensure the strength and stability of the reunification. In the case of a child who has been returned home, the services and activities shall only be provided during the 15-month period that begins on the date that the child returns home”.

(b) CONFORMING AMENDMENTS.—

(1) Section 430 of such Act ([42 U.S.C. 629](#)) is amended in the matter preceding paragraph (1), by striking “time-limited”.

(2) Subsections (a)(4), (a)(5)(A), and (b)(1) of section 432 of such Act ([42 U.S.C. 629b](#)) are amended by striking “time-limited” each place it appears.

## **SEC. 122. REDUCING BUREAUCRACY AND UNNECESSARY DELAYS WHEN PLACING CHILDREN IN HOMES ACROSS STATE LINES.**

(a) STATE PLAN REQUIREMENT.—Section 471(a)(25) of the Social Security Act ([42 U.S.C. 671\(a\)\(25\)](#)) is amended—

(1) by striking “provide” and insert “provides”; and

(2) by inserting “, which, not later than October 1, 2026, shall include the use of an electronic interstate case-processing system” before the first semicolon.

(b) GRANTS FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—Section 437 of such Act ([42 U.S.C. 629g](#)) is amended by adding at the end the following:

“(g) GRANTS FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—

“(1) PURPOSE.—The purpose of this subsection is to facilitate the development of an electronic interstate case-processing system for the exchange of data and documents to expedite the placements of children in foster, guardianship, or adoptive homes across State lines.

“(2) APPLICATION REQUIREMENTS.—A State that desires a grant under this subsection shall submit to the Secretary an application containing the following:

“(A) A description of the goals and outcomes to be achieved during the period for which grant funds are sought, which goals and outcomes must result in—

“(i) reducing the time it takes for a child to be provided with a safe and appropriate permanent living arrangement across State lines;

“(ii) improving administrative processes and reducing costs in the foster care system; and

“(iii) the secure exchange of relevant case files and other necessary materials in real time, and timely communications and placement decisions regarding interstate placements of children.

“(B) A description of the activities to be funded in whole or in part with the grant funds, including the sequencing of the activities.

“(C) A description of the strategies for integrating programs and services for children who are placed across State lines.

“(D) Such other information as the Secretary may require.

“(3) GRANT AUTHORITY.—The Secretary may make a grant to a State that complies with paragraph (2).

“(4) USE OF FUNDS.—A State to which a grant is made under this subsection shall use the grant to support the State in connecting with the electronic interstate case-processing system described in paragraph (1).

“(5) EVALUATIONS.—Not later than 1 year after the final year in which grants are awarded under this subsection, the Secretary shall submit to the Congress, and make available to the general public by posting on a website, a report that contains the following information:

“(A) How using the electronic interstate case-processing system developed pursuant to paragraph (4) has changed the time it takes for children to be placed across State lines.

“(B) The number of cases subject to the Interstate Compact on the Placement of Children that were processed through the electronic interstate case-processing system, and the number of interstate child placement cases that were processed outside the electronic interstate case-processing system, by each State in each year.

“(C) The progress made by States in implementing the electronic interstate case-processing system.

“(D) How using the electronic interstate case-processing system has affected various metrics related to child safety and well-being, including the time it takes for children to be placed across State lines.

“(E) How using the electronic interstate case-processing system has affected administrative costs and caseworker time spent on placing children across State lines.

“(6) DATA INTEGRATION.—The Secretary, in consultation with the Secretariat for the Interstate Compact on the Placement of Children and the States, shall assess how the electronic interstate case-processing system developed pursuant to paragraph (4) could be used to better serve and protect children that come to the attention of the child welfare system, by—

“(A) connecting the system with other data systems (such as systems operated by State law enforcement and judicial agencies, systems operated by the Federal Bureau of Investigation for the purposes of the Innocence Lost National Initiative, and other systems);

“(B) simplifying and improving reporting related to paragraphs (34) and (35) of section 471(a) regarding children or youth who have been identified as being a sex trafficking victim or children missing from foster care; and

“(C) improving the ability of States to quickly comply with background check requirements of section 471(a)(20), including checks of child abuse and neglect registries as required by section 471(a)(20)(B).”.

(c) RESERVATION OF FUNDS TO IMPROVE THE INTERSTATE PLACEMENT OF CHILDREN.—Section 437(b) of such Act ([42 U.S.C. 629g\(b\)](#)) is amended by adding at the end the following:

“(4) IMPROVING THE INTERSTATE PLACEMENT OF CHILDREN.—The Secretary shall reserve \$5,000,000 of the amount made available for fiscal year 2017 for grants under subsection (g), and the amount so reserved shall remain available through fiscal year 2021.”.

### **SEC. 123. ENHANCEMENTS TO GRANTS TO IMPROVE WELL-BEING OF FAMILIES AFFECTED BY SUBSTANCE ABUSE.**

Section 437(f) of the Social Security Act ([42 U.S.C. 629g\(f\)](#)) is amended—

(1) in the subsection heading, by striking “INCREASE THE WELL-BEING OF, AND TO IMPROVE THE PERMANENCY OUTCOMES FOR, CHILDREN AFFECTED BY” and inserting “IMPLEMENT IV–E PREVENTION SERVICES, AND IMPROVE THE WELL-BEING OF, AND IMPROVE PERMANENCY OUTCOMES FOR, CHILDREN AND FAMILIES AFFECTED BY HEROIN, OPIOIDS, AND OTHER”;

(2) by striking paragraph (2) and inserting the following:

“(2) REGIONAL PARTNERSHIP DEFINED.—In this subsection, the term ‘regional partnership’ means a collaborative agreement (which may be established on an interstate, State, or intrastate basis) entered into by the following:

“(A) MANDATORY PARTNERS FOR ALL PARTNERSHIP GRANTS.—

“(i) The State child welfare agency that is responsible for the administration of the State plan under this part and part E.

“(ii) The State agency responsible for administering the substance abuse prevention and treatment block grant provided under subpart II of part B of title XIX of the Public Health Service

Act.

“(B) MANDATORY PARTNERS FOR PARTNERSHIP GRANTS PROPOSING TO SERVE CHILDREN IN OUT-OF-HOME PLACEMENTS.—If the partnership proposes to serve children in out-of-home placements, the Juvenile Court or Administrative Office of the Court that is most appropriate to oversee the administration of court programs in the region to address the population of families who come to the attention of the court due to child abuse or neglect.

“(C) OPTIONAL PARTNERS.—At the option of the partnership, any of the following:

“(i) An Indian tribe or tribal consortium.

“(ii) Nonprofit child welfare service providers.

“(iii) For-profit child welfare service providers.

“(iv) Community health service providers, including substance abuse treatment providers.

“(v) Community mental health providers.

“(vi) Local law enforcement agencies.

“(vii) School personnel.

“(viii) Tribal child welfare agencies (or a consortia of the agencies).

“(ix) Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under a State plan approved under this subpart.

“(D) EXCEPTION FOR REGIONAL PARTNERSHIPS WHERE THE LEAD APPLICANT IS AN INDIAN TRIBE OR TRIBAL CONSORTIA.—If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this subsection, the Indian tribe or tribal consortium—

“(i) may (but is not required to) include the State child welfare agency as a partner in the collaborative agreement;

“(ii) may not enter into a collaborative agreement only with tribal child welfare agencies (or a consortium of the agencies); and

“(iii) if the condition described in paragraph (2)(B) applies, may include tribal court organizations in lieu of other judicial partners.”;

(3) in paragraph (3)—

(A) in subparagraph (A)—

(i) by striking “2012 through 2016” and inserting “2017 through 2021”; and

(ii) by striking “\$500,000 and not more than \$1,000,000” and inserting “\$250,000 and not more than \$1,000,000”;

(B) in subparagraph (B)—

(i) in the subparagraph heading, by inserting “; PLANNING” after “APPROVAL”;

(ii) in clause (i), by striking “clause (ii)” and inserting “clauses (ii) and (iii)”;

(iii) by adding at the end the following:

“(iii) SUFFICIENT PLANNING.—A grant awarded under this subsection shall be disbursed in two phases: a planning phase (not to exceed 2 years); and an implementation phase. The total disbursement to a grantee for the planning phase may not exceed \$250,000, and may not exceed the total anticipated funding for the implementation phase.”; and

(C) by adding at the end the following:

“(D) LIMITATION ON PAYMENT FOR A FISCAL YEAR.—No payment shall be made under subparagraph (A) or (C) for a fiscal year until the Secretary determines that the eligible partnership has made sufficient progress in meeting the goals of the grant and that the members of the eligible partnership are coordinating to a reasonable degree with the other members of the eligible partnership.”;

(4) in paragraph (4)—

(A) in subparagraph (B)—

(i) in clause (i), by inserting “, parents, and families” after “children”;

(ii) in clause (ii), by striking “safety and permanence for such children; and” and inserting “safe, permanent caregiving relationships for the children;”;

(iii) in clause (iii), by striking “or” and inserting “increase reunification rates for children who have been placed in out of home care, or decrease”; and

(iv) by redesignating clause (iii) as clause (v) and inserting after clause (ii) the following:

“(iii) improve the substance abuse treatment outcomes for parents including retention in treatment and successful completion of treatment;

“(iv) facilitate the implementation, delivery, and effectiveness of prevention services and programs under section 471(e); and”;

(B) in subparagraph (D), by striking “where appropriate,”; and

(C) by striking subparagraphs (E) and (F) and inserting the following:

“(E) A description of a plan for sustaining the services provided by or activities funded under the grant after the conclusion of the grant period, including through the use of prevention services and programs under section 471(e) and other funds provided to the State for child welfare and substance abuse prevention and treatment services.

“(F) Additional information needed by the Secretary to determine that the proposed activities and implementation will be consistent with research or evaluations showing which practices and approaches are most effective.”;

(5) in paragraph (5)(A), by striking “abuse treatment” and inserting “use disorder treatment including medication assisted treatment and in-home substance abuse disorder treatment and recovery”;

(6) in paragraph (7)—

(A) by striking “and” at the end of subparagraph (C); and

(B) by redesignating subparagraph (D) as subparagraph (E) and inserting after subparagraph (C) the following:

“(D) demonstrate a track record of successful collaboration among child welfare, substance abuse disorder treatment and mental health agencies; and”;

(7) in paragraph (8)—

(A) in subparagraph (A)—

(i) by striking “establish indicators that will be” and inserting “review indicators that are”; and

(ii) by striking “in using funds made available under such grants to achieve the purpose of this subsection” and inserting “and establish a set of core indicators related to child safety, parental recovery, parenting capacity, and family well-being. In developing the core indicators, to the extent possible, indicators shall be made consistent with the outcome measures described in section 471(e) (6)”;

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting “base the performance measures on lessons learned from prior rounds of regional partnership grants under this subsection, and” before “consult”; and

(ii) by striking clauses (iii) and (iv) and inserting the following:

“(iii) Other stakeholders or constituencies as determined by the Secretary.”;

(8) in paragraph (9)(A), by striking clause (i) and inserting the following:

“(i) SEMIANNUAL REPORTS.—Not later than September 30 of each fiscal year in which a recipient of a grant under this subsection is paid funds under the grant, and every 6 months thereafter, the grant recipient shall submit to the Secretary a report on the services provided and activities carried out during the reporting period, progress made in achieving the goals of the program, the number of children, adults, and families receiving services, and such additional information as the Secretary determines is necessary. The report due not later than September 30 of the last such fiscal year shall include, at a minimum, data on each of the performance indicators included in the evaluation of the regional partnership.”; and

(9) in paragraph (10), by striking “2012 through 2016” and inserting “2017 through 2021”.

## Subtitle C—Miscellaneous

### **SEC. 131. REVIEWING AND IMPROVING LICENSING STANDARDS FOR PLACEMENT IN A RELATIVE FOSTER FAMILY HOME.**

(a) IDENTIFICATION OF REPUTABLE MODEL LICENSING STANDARDS.—Not later than October 1, 2017, the Secretary of Health and Human Services shall identify reputable model licensing standards with respect to the licensing of foster family homes (as defined in section 472(c)(1) of the Social Security Act).

(b) STATE PLAN REQUIREMENT.—Section 471(a) of the Social Security Act ([42 U.S.C. 671\(a\)](#)) is amended—

(1) in paragraph (34)(B), by striking “and” after the semicolon;

(2) in paragraph (35)(B), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(36) provides that, not later than April 1, 2018, the State shall submit to the Secretary information addressing—

“(A) whether the State licensing standards are in accord with model standards identified by the Secretary, and if not, the reason for the specific deviation and a description as to why having a standard that is reasonably in accord with the corresponding national model standards is not appropriate for the State;

“(B) whether the State has elected to waive standards established in 471(a)(10)(A) for relative foster family homes (pursuant to waiver authority provided by 471(a)(10)(D)), a description of which standards the State most commonly waives, and if the State has not elected to waive the standards, the reason for not waiving these standards;

“(C) if the State has elected to waive standards specified in subparagraph (B), how caseworkers are trained to use the waiver authority and whether the State has developed a process or provided tools to assist caseworkers in waiving nonsafety standards per the authority provided in 471(a)(10)(D) to quickly place children with relatives; and



“(D) a description of the steps the State is taking to improve caseworker training or the process, if any; and”.

### **SEC. 132. DEVELOPMENT OF A STATEWIDE PLAN TO PREVENT CHILD ABUSE AND NEGLECT FATALITIES.**

Section 422(b)(19) of the Social Security Act ([42 U.S.C. 622\(b\)\(19\)](#)) is amended to read as follows:

“(19) document steps taken to track and prevent child maltreatment deaths by including—

“(A) a description of the steps the State is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the State agency referred to in paragraph (1), including gathering relevant information on the deaths from the relevant organizations in the State including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners or coroners; and

“(B) a description of the steps the State is taking to develop and implement of a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.”.

### **SEC. 133. MODERNIZING THE TITLE AND PURPOSE OF TITLE IV–E.**

(a) **PART HEADING.**—The heading for part E of title IV of the Social Security Act ([42 U.S.C. 670 et seq.](#)) is amended to read as follows:

#### **“PART E—FEDERAL PAYMENTS FOR FOSTER CARE, PREVENTION, AND PERMANENCY”.**

(b) **PURPOSE.**—The first sentence of section 470 of such Act ([42 U.S.C. 670](#)) is amended—

(1) by striking “1995) and” and inserting “1995),”;

(2) by inserting “kinship guardianship assistance, and prevention services or programs specified in section 471(e)(1),” after “needs,”; and

(3) by striking “(commencing with the fiscal year which begins October 1, 1980)”.

### **SEC. 134. EFFECTIVE DATES.**

(a) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), subject to subsection (b), the amendments made by this title shall take effect on October 1, 2017.

(2) **EXCEPTIONS.**—The amendments made by sections 131 and 133 shall take effect on the date of enactment of this Act.

(b) **TRANSITION RULE.**—

(1) **IN GENERAL.**—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this title, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(2) **APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.**—In the case of an Indian tribe, tribal organization, or tribal consortium which the Secretary of Health and Human Services determines requires time to take action necessary to comply with the additional requirements imposed by the amendments made by this title (whether the tribe, organization, or tribal consortium has a plan under section 479B of the Social Security Act or a cooperative agreement or contract entered into with a State), the Secretary shall provide the tribe, organization, or tribal consortium with such additional time as the Secretary determines is necessary for the tribe, organization, or tribal consortium to take the action to comply with the additional requirements before being regarded as failing to comply with the requirements.

## **TITLE II—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME**

### **SEC. 201. LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES.**

(a) **LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.**—

(1) **IN GENERAL.**—Section 472 of the Social Security Act ([42 U.S.C. 672](#)), as amended by section 112, is amended—

(A) in subsection (a)(2)(C), by inserting “, but only to the extent permitted under subsection (k)” after “institution”; and

(B) by adding at the end the following:

“(k) **LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.**—

“(1) **IN GENERAL.**—Beginning with the third week for which foster care maintenance payments are made under this section on behalf of a child placed in a child-care institution, no Federal payment shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child unless—

“(A) the child is placed in a child-care institution that is a setting specified in paragraph (2) (or is placed in a licensed residential family-based treatment facility consistent with subsection (j)); and

“(B) in the case of a child placed in a qualified residential treatment program (as defined in paragraph (4)), the requirements specified in paragraph (3) and section 475A(c) are met.

“(2) SPECIFIED SETTINGS FOR PLACEMENT.—The settings for placement specified in this paragraph are the following:

“(A) A qualified residential treatment program (as defined in paragraph (4)).

“(B) A setting specializing in providing prenatal, post-partum, or parenting supports for youth.

“(C) In the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently.

“(3) ASSESSMENT TO DETERMINE APPROPRIATENESS OF PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—

“(A) DEADLINE FOR ASSESSMENT.—In the case of a child who is placed in a qualified residential treatment program, if the assessment required under section 475A(c)(1) is not completed within 30 days after the placement is made, no Federal payment shall be made to the State under section 474(a)(1) for any amounts expended for foster care maintenance payments on behalf of the child during the placement.

“(B) DEADLINE FOR TRANSITION OUT OF PLACEMENT.—If the assessment required under section 475A(c)(1) determines that the placement of a child in a qualified residential treatment program is not appropriate, a court disapproves such a placement under section 475A(c)(2), or a child who has been in an approved placement in a qualified residential treatment program is going to return home or be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home, Federal payments shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child while the child remains in the qualified residential treatment program only during the period necessary for the child to transition home or to such a placement. In no event shall a State receive Federal payments under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of a child who remains placed in a qualified residential treatment program after the end of the 30-day period that begins on the date a determination is made that the placement is no longer the recommended or approved placement for the child.

“(4) QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—For purposes of this part, the term ‘qualified residential treatment program’ means a program that—

“(A) has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 475A(c);

“(B) has registered or licensed nursing staff and other licensed clinical staff who—

“(i) provide care within the scope of their practice as defined by State law;

“(ii) are on-site during business hours; and

“(iii) are available 24 hours a day and 7 days a week;

“(C) to the extent appropriate, and in accordance with the child’s best interests, facilitates participation of family members in the child’s treatment program;

“(D) facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;

“(E) documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;

“(F) provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and

“(G) is licensed in accordance with section 471(a)(10) and is accredited by any of the following independent, not-for-profit organizations:

“(i) The Commission on Accreditation of Rehabilitation Facilities (CARF).

“(ii) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

“(iii) The Council on Accreditation (COA).

“(iv) Any other independent, not-for-profit accrediting organization approved by the Secretary.”.

(2) CONFORMING AMENDMENT.—Section 474(a)(1) of the Social Security Act ([42 U.S.C. 674\(a\)\(1\)](#)), as amended by section 112(b), is amended by striking “section 472(j)” and inserting “subsections (j) and (k) of section 472”.

(b) DEFINITION OF FOSTER FAMILY HOME, CHILD-CARE INSTITUTION.—Section 472(c) of such Act ([42 U.S.C. 672\(c\)\(1\)](#)) is amended to read as follows:

“(c) DEFINITIONS.—For purposes of this part:

“(1) FOSTER FAMILY HOME.—

“(A) IN GENERAL.—The term ‘foster family home’ means the home of an individual or family—

“(i) that is licensed or approved by the State in which it is situated as a foster family home that meets the standards established for the licensing or approval; and

“(ii) in which a child in foster care has been placed in the care of an individual, who resides with the child and who has been licensed or approved by the State to be a foster parent—

“(I) that the State deems capable of adhering to the reasonable and prudent parent standard;

“(II) that provides 24-hour substitute care for children placed away from their parents or other caretakers; and

“(III) that provides the care for not more than six children in foster care.

“(B) STATE FLEXIBILITY.—The number of foster children that may be cared for in a home under subparagraph (A) may exceed the numerical limitation in subparagraph (A)(ii)(III), at the option of the State, for any of the following reasons:

“(i) To allow a parenting youth in foster care to remain with the child of the parenting youth.

“(ii) To allow siblings to remain together.

“(iii) To allow a child with an established meaningful relationship with the family to remain with the family.

“(iv) To allow a family with special training or skills to provide care to a child who has a severe disability.

“(C) RULE OF CONSTRUCTION.—Subparagraph (A) shall not be construed as prohibiting a foster parent from renting the home in which the parent cares for a foster child placed in the parent’s care.

“(2) CHILD-CARE INSTITUTION.—

“(A) IN GENERAL.—The term ‘child-care institution’ means a private child-care institution, or a public child-care institution which accommodates no more than 25 children, which is licensed by the State in which it is situated or has been approved by the agency of the State responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing.

“(B) SUPERVISED SETTINGS.—In the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations.

“(C) EXCLUSIONS.—The term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.”.

(c) TRAINING FOR STATE JUDGES, ATTORNEYS, AND OTHER LEGAL PERSONNEL IN CHILD WELFARE CASES.—Section 438(b)(1) of such Act ([42 U.S.C. 629h\(b\)\(1\)](#)) is amended in the matter preceding subparagraph (A) by inserting “shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are placed in settings that are not a foster family home,” after “with respect to the child,”.

(d) ASSURANCE OF NONIMPACT ON JUVENILE JUSTICE SYSTEM.—

(1) STATE PLAN REQUIREMENT.—Section 471(a) of such Act ([42 U.S.C. 671\(a\)](#)), as amended by section 131, is further amended by adding at the end the following:

“(37) includes a certification that, in response to the limitation imposed under section 472(k) with respect to foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, the State will not enact or advance policies or practices that would result in a significant increase in the population of youth in the State’s juvenile justice system.”.

(2) GAO STUDY AND REPORT.—The Comptroller General of the United States shall evaluate the impact, if any, on State juvenile justice systems of the limitation imposed under section 472(k) of the Social Security Act (as added by section 201(a)(1)) on foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, in accordance with the amendments made by subsections (a) and (b) of this section. In particular, the Comptroller General shall evaluate the extent to which children in foster care who also are subject to the juvenile justice system of the State are placed in a facility under the jurisdiction of the juvenile justice system and whether the lack of available congregate care placements under the jurisdiction of the child welfare systems is a contributing factor to that result. Not later than December 31, 2023, the Comptroller General shall submit to Congress a report on the results of the evaluation.

**SEC. 202. ASSESSMENT AND DOCUMENTATION OF THE NEED FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.**

Section 475A of the Social Security Act ([42 U.S.C. 675a](#)) is amended by adding at the end the following:

“(c) ASSESSMENT, DOCUMENTATION, AND JUDICIAL DETERMINATION REQUIREMENTS FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—In the case of any child who is placed in a qualified residential treatment program (as defined in section 472(k)(4)), the following requirements shall apply for purposes of approving the case plan for the child and the case system review procedure for the child:

“(1)(A) Within 30 days of the start of each placement in such a setting, a qualified individual (as defined in subparagraph (D)) shall—

“(i) assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by the Secretary;

“(ii) determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting from among the settings specified in section 472(k)(2) would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

“(iii) develop a list of child-specific short- and long-term mental and behavioral health goals.

“(B)(i) The State shall assemble a family and permanency team for the child in accordance with the requirements of clauses (ii) and (iii). The qualified individual conducting the assessment required under subparagraph (A) shall work in conjunction with the family of, and permanency team for, the child while conducting and making the assessment.

“(ii) The family and permanency team shall consist of all appropriate biological family members, relative, and fictive kin of the child, as well as, as appropriate, professionals who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy. In the case of a child who has attained age 14, the family and permanency team shall include the members of the permanency planning team for the child that are selected by the child in accordance with section 475(5)(C) (iv).

“(iii) The State shall document in the child's case plan—

“(I) the reasonable and good faith effort of the State to identify and include all such individuals on the family of, and permanency team for, the child;

“(II) all contact information for members of the family and permanency team, as well as contact information for other family members and fictive kin who are not part of the family and permanency team;

“(III) evidence that meetings of the family and permanency team, including meetings relating to the assessment required under subparagraph (A), are held at a time and place convenient for family;

“(IV) if reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency team;

“(V) evidence that the assessment required under subparagraph (A) is determined in conjunction with the family and permanency team; and

“(VI) the placement preferences of the family and permanency team relative to the assessment and, if the placement preferences of the family and permanency team and child are not the placement setting recommended by the qualified individual conducting the assessment under subparagraph (A), the reasons why the preferences of the team and of the child were not recommended.

“(C) In the case of a child who the qualified individual conducting the assessment under subparagraph (A) determines should not be placed in a foster family home, the qualified individual shall specify in writing the reasons why the needs of the child cannot be met by the family of the child or in a foster family home. A shortage or lack of foster family homes shall not be an acceptable reason for determining that a needs of the child cannot be met in a foster family home. The qualified individual also shall specify in writing why the recommended placement in a qualified residential treatment program is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.

“(D)(i) Subject to clause (ii), in this subsection, the term ‘qualified individual’ means a trained professional or licensed clinician who is not an employee of the State agency and who is not connected to, or

affiliated with, any placement setting in which children are placed by the State.

“(ii) The Secretary may approve a request of a State to waive any requirement in clause (i) upon a submission by the State, in accordance with criteria established by the Secretary, that certifies that the trained professionals or licensed clinicians with responsibility for performing the assessments described in subparagraph (A) shall maintain objectivity with respect to determining the most effective and appropriate placement for a child.

“(2) Within 60 days of the start of each placement in a qualified residential treatment program, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, shall—

“(A) consider the assessment, determination, and documentation made by the qualified individual conducting the assessment under paragraph (1);

“(B) determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

“(C) approve or disapprove the placement.

“(3) The written documentation made under paragraph (1)(C) and documentation of the determination and approval or disapproval of the placement in a qualified residential treatment program by a court or administrative body under paragraph (2) shall be included in and made part of the case plan for the child.

“(4) As long as a child remains placed in a qualified residential treatment program, the State agency shall submit evidence at each status review and each permanency hearing held with respect to the child—

“(A) demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;

“(B) documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and

“(C) documenting the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

“(5) In the case of any child who is placed in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or nonconsecutive months), the State agency shall submit to the Secretary—



“(A) the most recent versions of the evidence and documentation specified in paragraph (4); and

“(B) the signed approval of the head of the State agency for the continued placement of the child in that setting.”.

### **SEC. 203. PROTOCOLS TO PREVENT INAPPROPRIATE DIAGNOSES.**

(a) **STATE PLAN REQUIREMENT.**—Section 422(b)(15)(A) of the Social Security Act ([42 U.S.C. 622\(b\)\(15\)](#)) ([\(A\)](#)) is amended—

(1) in clause (vi), by striking “and” after the semicolon;

(2) by redesignating clause (vii) as clause (viii); and

(3) by inserting after clause (vi) the following:

“(vii) the procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and”.

(b) **EVALUATION.**—Section 476 of such Act ([42 U.S.C. 676](#)), as amended by section 111(d), is further amended by adding at the end the following:

“(e) **EVALUATION OF STATE PROCEDURES AND PROTOCOLS TO PREVENT INAPPROPRIATE DIAGNOSES OF MENTAL ILLNESS OR OTHER CONDITIONS.**—The Secretary shall conduct an evaluation of the procedures and protocols established by States in accordance with the requirements of section 422(b)(15)(A) (vii). The evaluation shall analyze the extent to which States comply with and enforce the procedures and protocols and the effectiveness of various State procedures and protocols and shall identify best practices. Not later than January 1, 2019, the Secretary shall submit a report on the results of the evaluation to Congress.”.

### **SEC. 204. ADDITIONAL DATA AND REPORTS REGARDING CHILDREN PLACED IN A SETTING THAT IS NOT A FOSTER FAMILY HOME.**

Section 479A(a)(7)(A) of the Social Security Act ([42 U.S.C. 679b\(a\)\(7\)\(A\)](#)) is amended by striking clauses (i) through (vi) and inserting the following:

“(i) with respect to each such placement—

“(I) the type of the placement setting, including whether the placement is shelter care, a group home and if so, the range of the child population in the home, a residential treatment facility, a hospital or institution providing medical, rehabilitative, or psychiatric care, a setting specializing in providing prenatal, post-partum or parenting supports, or some other kind of child-care institution and if so, what kind;

“(II) the number of children in the placement setting and the age, race, ethnicity, and gender of each of the children;

“(III) for each child in the placement setting, the length of the placement of the child in the setting, whether the placement of the child in the setting is the first placement of the child and if not, the number and type of previous placements of the child, and whether the child has special needs or another diagnosed mental or physical illness or condition; and

“(IV) the extent of any specialized education, treatment, counseling, or other services provided in the setting; and

“(ii) separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement; and”.

## **SEC. 205. EFFECTIVE DATES; APPLICATION TO WAIVERS.**

### **(a) EFFECTIVE DATES.—**

(1) **IN GENERAL.**—Subject to paragraph (2) and subsections (b) and (c), the amendments made by this title shall take effect on October 1, 2017.

(2) **TRANSITION RULE.**—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this title, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet the additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(b) **LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES AND RELATED PROVISIONS.**—The amendments made by sections 201(a), 201(b), 201(d), and 202 shall take effect on October 1, 2019.

(c) **APPLICATION TO STATES WITH WAIVERS.**—In the case of a State that, on the date of enactment of this Act, has in effect a waiver approved under section 1130 of the Social Security Act ([42 U.S.C. 1320a–9](#)), the amendments made by this title shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments are inconsistent with the terms of the waiver.

## **TITLE III—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES**

### **SEC. 301. SUPPORTING AND RETAINING FOSTER FAMILIES FOR CHILDREN.**

(a) **SUPPORTING AND RETAINING FOSTER PARENTS AS A FAMILY SUPPORT SERVICE.**—Section 431(a)(2)(B) of the Social Security Act ([42 U.S.C. 631\(a\)\(2\)\(B\)](#)) is amended by redesignating clauses (iii) through (vi) as clauses (iv) through (vii), respectively, and inserting after clause (ii) the following:

“(iii) To support and retain foster families so they can provide quality family-based settings for children in foster care.”.

(b) **SUPPORT FOR FOSTER FAMILY HOMES.**—Section 436 of such Act ([42 U.S.C. 629f](#)) is amended by adding at the end the following:

“(c) **SUPPORT FOR FOSTER FAMILY HOMES.**—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2018, \$8,000,000 for the Secretary to make competitive grants to States, Indian tribes, or tribal consortia to support the recruitment and retention of high-quality foster families to increase their capacity to place more children in family settings, focused on States, Indian tribes, or tribal consortia with the highest percentage of children in non-family settings. The amount appropriated under this subparagraph shall remain available through fiscal year 2022.”.

### **SEC. 302. EXTENSION OF CHILD AND FAMILY SERVICES PROGRAMS.**

(a) **EXTENSION OF STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM.**—Section 425 of the Social Security Act ([42 U.S.C. 625](#)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(b) **EXTENSION OF PROMOTING SAFE AND STABLE FAMILIES PROGRAM AUTHORIZATIONS.**—

(1) **IN GENERAL.**—Section 436(a) of such Act ([42 U.S.C. 629f\(a\)](#)) is amended by striking all that follows “\$345,000,000” and inserting “for each of fiscal years 2017 through 2021”.

(2) **DISCRETIONARY GRANTS.**—Section 437(a) of such Act ([42 U.S.C. 629g\(a\)](#)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(c) **EXTENSION OF FUNDING RESERVATIONS FOR MONTHLY CASEWORKER VISITS AND REGIONAL PARTNERSHIP GRANTS.**—Section 436(b) of such Act ([42 U.S.C. 629f\(b\)](#)) is amended—

(1) in paragraph (4)(A), by striking “2012 through 2016” and inserting “2017 through 2021”; and

(2) in paragraph (5), by striking “2012 through 2016” and inserting “2017 through 2021”.

(d) **REAUTHORIZATION OF FUNDING FOR STATE COURTS.**—

(1) **EXTENSION OF PROGRAM.**—Section 438(c)(1) of such Act ([42 U.S.C. 629h\(c\)\(1\)](#)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(2) **EXTENSION OF FEDERAL SHARE.**—Section 438(d) of such Act ([42 U.S.C. 629h\(d\)](#)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(e) **REPEAL OF EXPIRED PROVISIONS.**—Section 438(e) of such Act ([42 U.S.C. 629h\(e\)](#)) is repealed.

### **SEC. 303. IMPROVEMENTS TO THE JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM AND RELATED PROVISIONS.**

(a) **AUTHORITY TO SERVE FORMER FOSTER YOUTH UP TO AGE 23.**—Section 477 of the Social Security Act ([42 U.S.C. 677](#)) is amended—

(1) in subsection (a)(5), by inserting “(or 23 years of age, in the case of a State with a certification under subsection (b)(3)(A)(ii) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with such subsection)” after “21 years of age”;

(2) in subsection (b)(3)(A)—

(A) by inserting “(i)” before “A certification”;

(B) by striking “children who have left foster care” and all that follows through the period and inserting “youths who have aged out of foster care and have not attained 21 years of age.”; and

(C) by adding at the end the following:

“(ii) If the State has elected under section 475(8)(B) to extend eligibility for foster care to all children who have not attained 21 years of age, or if the Secretary determines that the State agency responsible for administering the State plans under this part and part B uses State funds or any other funds not provided under this part to provide services and assistance for youths who have aged out of foster care that are comparable to the services and assistance the youths would receive if the State had made such an election, the certification required under clause (i) may provide that the State will provide assistance and services to youths who have aged out of foster care and have not attained 23 years of age.”; and

(3) in subsection (b)(3)(B), by striking “children who have left foster care” and all that follows through the period and inserting “youths who have aged out of foster care and have not attained 21 years of age (or 23 years of age, in the case of a State with a certification under subparagraph (A)(i) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with subparagraph (A)(ii)).”.

(b) **AUTHORITY TO REDISTRIBUTE UNSPENT FUNDS.**—Section 477(d) of such Act ([42 U.S.C. 677\(d\)](#)) is amended—

(1) in paragraph (4), by inserting “or does not expend allocated funds within the time period specified under section 477(d)(3)” after “provided by the Secretary”; and

(2) by adding at the end the following:

“(5) **REDISTRIBUTION OF UNEXPENDED AMOUNTS.**—

“(A) **AVAILABILITY OF AMOUNTS.**—To the extent that amounts paid to States under this section in a fiscal year remain unexpended by the States at the end of the succeeding fiscal year, the Secretary may make the amounts available for redistribution in the second succeeding fiscal year among the States that apply for additional funds under this section for that second succeeding fiscal year.

“(B) **REDISTRIBUTION.**—

“(i) IN GENERAL.—The Secretary shall redistribute the amounts made available under subparagraph (A) for a fiscal year among eligible applicant States. In this subparagraph, the term ‘eligible applicant State’ means a State that has applied for additional funds for the fiscal year under subparagraph (A) if the Secretary determines that the State will use the funds for the purpose for which originally allotted under this section.

“(ii) AMOUNT TO BE REDISTRIBUTED.—The amount to be redistributed to each eligible applicant State shall be the amount so made available multiplied by the State foster care ratio (as defined in subsection (c)(4), except that, in such subsection, ‘all eligible applicant States (as defined in subsection (d)(5)(B)(i))’ shall be substituted for ‘all States’).

“(iii) TREATMENT OF REDISTRIBUTED AMOUNT.—Any amount made available to a State under this paragraph shall be regarded as part of the allotment of the State under this section for the fiscal year in which the redistribution is made.

“(C) TRIBES.—For purposes of this paragraph, the term ‘State’ includes an Indian tribe, tribal organization, or tribal consortium that receives an allotment under this section.”.

(c) EXPANDING AND CLARIFYING THE USE OF EDUCATION AND TRAINING VOUCHERS.—

(1) IN GENERAL.—Section 477(i)(3) of such Act ([42 U.S.C. 677\(i\)\(3\)](#)) is amended—

(A) by striking “on the date” and all that follows through “23” and inserting “to remain eligible until they attain 26”; and

(B) by inserting “, but in no event may a youth participate in the program for more than 5 years (whether or not consecutive)” before the period.

(2) CONFORMING AMENDMENT.—Section 477(i)(1) of such Act ([42 U.S.C. 677\(i\)\(1\)](#)) is amended by inserting “who have attained 14 years of age” before the period.

(d) OTHER IMPROVEMENTS.—Section 477 of such Act ([42 U.S.C. 677](#)), as amended by subsections (a), (b), and (c), is amended—

(1) in the section heading, by striking “**INDEPENDENCE PROGRAM**” and inserting “**PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD**”;

(2) in subsection (a)—

(A) in paragraph (1)—

(i) by striking “identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services” and inserting “support all youth who have experienced foster care at age 14 or older in their transition to adulthood through transitional services”;

(ii) by inserting “and post-secondary education” after “high school diploma”; and

(iii) by striking “training in daily living skills, training in budgeting and financial management skills” and inserting “training and opportunities to practice daily living skills (such as financial literacy training and driving instruction)”;

(B) in paragraph (2), by striking “who are likely to remain in foster care until 18 years of age receive the education, training, and services necessary to obtain employment” and inserting “who have experienced foster care at age 14 or older achieve meaningful, permanent connections with a caring adult”;

(C) in paragraph (3), by striking “who are likely to remain in foster care until 18 years of age prepare for and enter postsecondary training and education institutions” and inserting “who have experienced foster care at age 14 or older engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience”; and

(D) by striking paragraph (4) and redesignating paragraphs (5) through (8) as paragraphs (4) through (7);

(3) in subsection (b)—

(A) in paragraph (2)(D), by striking “adolescents” and inserting “youth”; and

(B) in paragraph (3)—

(i) in subparagraph (D)—

(I) by inserting “including training on youth development” after “to provide training”; and

(II) by striking “adolescents preparing for independent living” and all that follows through the period and inserting “youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult.”;

(ii) in subparagraph (H), by striking “adolescents” each place it appears and inserting “youth”; and

(iii) in subparagraph (K)—

(I) by striking “an adolescent” and inserting “a youth”; and

(II) by striking “the adolescent” each place it appears and inserting “the youth”; and

(4) in subsection (f), by striking paragraph (2) and inserting the following:

“(2) REPORT TO CONGRESS.—Not later than October 1, 2017, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate

a report on the National Youth in Transition Database and any other databases in which States report outcome measures relating to children in foster care and children who have aged out of foster care or left foster care for kinship guardianship or adoption. The report shall include the following:

“(A) A description of the reasons for entry into foster care and of the foster care experiences, such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the National Youth in Transition Database and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17.

“(B) A description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 to the National Youth in Transition Database.

“(C) Benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans the executive branch will take to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care.

“(D) An analysis of the association between types of placement, number of overall placements, time spent in foster care, and other factors, and outcomes at ages 19 and 21.

“(E) An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among States.”.

(e) CLARIFYING DOCUMENTATION PROVIDED TO FOSTER YOUTH LEAVING FOSTER CARE.—Section 475(5)(I) of such Act ([42 U.S.C. 675\(5\)\(I\)](#)) is amended by inserting after “REAL ID Act of 2005” the following: “, and any official documentation necessary to prove that the child was previously in foster care”.

## **TITLE IV—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP**

### **SEC. 401. REAUTHORIZING ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PROGRAMS.**

Section 473A of the Social Security Act ([42 U.S.C. 673b](#)) is amended—

- (1) in subsection (b)(4), by striking “2013 through 2015” and inserting “2016 through 2020”;
- (2) in subsection (h)(1)(D), by striking “2016” and inserting “2021”; and
- (3) in subsection (h)(2), by striking “2016” and inserting “2021”.

## **TITLE V—TECHNICAL CORRECTIONS**

### **SEC. 501. TECHNICAL CORRECTIONS TO DATA EXCHANGE STANDARDS TO IMPROVE PROGRAM COORDINATION.**

(a) IN GENERAL.—Section 440 of the Social Security Act ([42 U.S.C. 629m](#)) is amended to read as follows:

**“SEC. 440. DATA EXCHANGE STANDARDS FOR IMPROVED INTEROPERABILITY.**

“(a) DESIGNATION.—The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part—

“(1) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

“(2) Federal reporting and data exchange required under applicable Federal law.

“(b) REQUIREMENTS.—The data exchange standards required by paragraph (1) shall, to the extent practicable—

“(1) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the eXtensible Markup Language;

“(2) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

“(3) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

“(4) be consistent with and implement applicable accounting principles;

“(5) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

“(6) be capable of being continually upgraded as necessary.

“(c) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a change to existing data exchange standards found to be effective and efficient.”.

(b) EFFECTIVE DATE.—Not later than the date that is 24 months after the date of the enactment of this section, the Secretary of Health and Human Services shall issue a proposed rule that—

(1) identifies federally required data exchanges, includes specification and timing of exchanges to be standardized, and addresses the factors used in determining whether and when to standardize data exchanges; and

(2) specifies State implementation options and describes future milestones.

**SEC. 502. TECHNICAL CORRECTIONS TO STATE REQUIREMENT TO ADDRESS THE DEVELOPMENTAL NEEDS OF YOUNG CHILDREN.**

Section 422(b)(18) of the Social Security Act ([42 U.S.C. 622\(b\)\(18\)](#)) is amended by striking “such children” and inserting “all vulnerable children under 5 years of age”.



## **TITLE VI—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE**

### **SEC. 601. DELAY OF ADOPTION ASSISTANCE PHASE-IN.**

Section 473(e)(1) of the Social Security Act ([42 U.S.C. 673\(e\)\(1\)](#)) is amended—

(1) in subparagraph (A), by striking “fiscal year” each place it appears and inserting “period”; and

(2) in subparagraph (B)—

(A) in the matter preceding the table, by striking “fiscal year” and inserting “period”; and

(B) in the table—

(i) by striking “of fiscal year:” and inserting “of.”;

(ii) by striking “2010” and inserting “Fiscal year 2010”;

(iii) by striking “2011” and inserting “Fiscal year 2011”;

(iv) by striking “2012” and inserting “Fiscal year 2012”;

(v) by striking “2013” and inserting “Fiscal year 2013”;

(vi) by striking “2014” and inserting “Fiscal year 2014”;

(vii) by striking “2015” and inserting “Fiscal year 2015”;

(viii) by striking “2016” and inserting “October 1, 2015, through March 31, 2019”;

(ix) by striking “2017” and inserting “April 1, 2019, through March 31, 2020”; and

(x) by striking “2018” and inserting “April 1, 2020.”.

### **SEC. 602. GAO STUDY AND REPORT ON STATE REINVESTMENT OF SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE.**

(a) **STUDY.**—The Comptroller General of the United States shall study the extent to which States are complying with the requirements of section 473(a)(8) of the Social Security Act relating to the effects of phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of the Social Security Act, as enacted by section 402 of the Fostering Connections to Success and Increasing Adoptions Act of 2008 ([Public Law 110–351](#); 122 Stat. 3975) and amended by section 206 of the Preventing Sex Trafficking and Strengthening Families Act ([Public Law 113–183](#); 128 Stat. 1919). In particular, the Comptroller General shall analyze the extent to which States are complying with the following requirements under section 473(a)(8)(D) of the Social Security Act:

(1) The requirement to spend an amount equal to the amount of the savings (if any) in State expenditures under part E of title IV of the Social Security resulting from phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of such Act to provide to children of families any service that may be provided under part B or E of title IV of such Act.

(2) The requirement that a State shall spend not less than 30 percent of the amount of any savings described in subparagraph (A) on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least  $\frac{2}{3}$  of the spending by the State to comply with the 30-percent requirement being spent on post-adoption and post-guardianship services.

(b) REPORT.—The Comptroller General of the United States shall submit to the Committee on Finance of the Senate, the Committee on Ways and Means of the House of Representatives, and the Secretary of Health and Human Services a report that contains the results of the study required by subsection (a), including recommendations to ensure compliance with laws referred to in subsection (a).



**Criminal Records Assessment & Exemption Requirements  
As of January 1, 2018 (per changes in AB 404 & SB 213)**

**FOR EMERGENCY PLACEMENT**

**Who must submit to a criminal records check?**

1. All persons over 18 living in the home excluding a NMD
2. Any person over 18 regularly present in the home other than those providing professional services (at the discretion of the county welfare department)
3. Any person over 14 who the department believes may have criminal record (at the discretion of the county welfare department), but this does not apply to children under the jurisdiction of the juvenile court. *WIC §361.4(a)(2)*

**How is the check done?** California Law Enforcement Telecommunications System (“CLETS”) *WIC §361.4(a)(2)*  
Within 10 days of CLETS or 5 days of emergency placement (whichever is sooner), the social worker shall ensure that a fingerprint clearance check is obtained through the DOJ. *WIC §361.4(c)*

**If there is no criminal record...**a child may be placed on the home on an emergency basis. *WIC 361.4(b)(1)*

**If there are arrests...**an arrest record shall not be used to deny or rescind an approval unless the department investigates the incident and secures evidence to establish conduct by the person that may pose a risk to the health and safety of any person who is or may become a client. *HS§1522(e)(1)*

However, if a prospective caregiver has been arrested for any of these crimes, there must be an investigation and a child cannot be placed until the agency & courts have considered the investigation results when determining whether placement is in the best interests of a child. *WIC §361.4(b)(4)*

Any crime listed in Penal Code 290: sex offender registry
Penal Code 245: assault with a deadly weapon
Penal Code 273ab: willful injury to a child 8 years of age or younger
Penal Code 273.5: corporal injury to spouse
Penal Code 273a(b): misdemeanor willful injury to a child
Penal Code 273a, paragraph 2 (prior to 1994)

**If there are convictions other than minor traffic violations...**

For convictions in Category 1 (see chart), a child cannot be placed in the home. *WIC §361.4(b)(5)*

For all other convictions, a child cannot be placed until an exemption has been granted. *WIC §361.4(b)(2)*

**EXCEPTION:** A child can be placed pending an exemption if the deputy director or director of the county welfare department, or his or her designee, determines that the placement is in the best interests of the child and a party to the case does not object. *WIC §361.4(b)(3)*

**EXCEPTION TO THE EXCEPTION:** No child can be placed pending an exemption for a misdemeanor conviction for statutory rape, indecent exposure or financial abuse of an elder. Due to a drafting error, SB 213 also inadvertently prohibits placement pending an exemption for misdemeanor convictions within the last five years. This will likely be fixed by state policy or in clean-up legislation. *WIC §361.4(b)(3)*

## FOR RESOURCE FAMILY APPROVAL

### **Who must submit to a criminal records check?**

Each resource family applicant and all adults residing in or regularly present in the home.

*WIC §16519.5(d)(2)(A)(i)(I)*

EXCEPTION: Those exempt from fingerprinting as set forth in *HS §1522(b)*. Includes:

1. Adult friends & family who come into the home for no longer than defined by Department in regulations (defined in Written Directives, Version 4.1 as one month) provided they are not left alone with the child. However, the foster parent acting as a reasonable and prudent parent may allow the adult friend/family to provide short-term care as a babysitter.
2. Parents of the child's friend who the child is visiting in the friend's home provided the friend, foster parent or both are present. However, the foster parent acting as a reasonable and prudent parent may allow the friend's parent to provide short-term care as a babysitter without the friend being present.
3. Individuals engaged by the foster parent to provide short-term care to the child for periods not to exceed 24 hours. Caregivers shall use a reasonable and prudent parent standard in selecting appropriate individuals to act as short-term babysitters.

EXCEPTION TO THE EXCEPTION: Written Directives, Version 4.1 indicate that a County can require a background check for an exempt individual, provided that the individual has contact that may pose a risk to the health and safety of a child or NMD placed with an applicant/Resource Family. *SECTION 6-03A: Background Check*

### **How is the check done?**

Receipt of a fingerprint-based state and federal criminal offender record information search response.

*WIC §16519.5(d)(2)(A)(i)(I)*

**If there are arrests...** a County shall consider the information and may conduct an investigation. The individual to whom the conviction or arrest pertains shall submit a written signed statement concerning the circumstances of each conviction or arrest. An investigation of the facts regarding arrests or convictions may lead to a denial of Resource Family Approval.

However, if an individual's criminal record indicates an arrest for an offense specified in Health & Safety Code § 1522(e) (see box on previous page), the County must conduct an investigation before an exemption or clearance can be granted.

If a County finds that an individual is awaiting trial, including an active warrant for an arrest, it may cease processing the criminal record information until the conclusion of the trial.

*Written Directives, Version 4.1, SECTION 6-03A: Background Check*

### **If there are convictions other than minor traffic violations...**

For convictions in Category 1, the applicant cannot receive a resource family approval.

*WIC §16519.5(d)(2)(A)(i)(III)*

For convictions in Category 2 or 3, the applicant cannot receive a resource family approval unless an exemption has been granted. *WIC §16519.5(d)(2)(A)(i)(III)*

<b>CATEGORY 1: NON-EXEMPTIBLE HS §1522(g)(2)(A)(i-iii)</b>	Felony conviction for child abuse or neglect
	Felony conviction for spousal abuse
	Felony conviction for crimes against a child, including child pornography
	Felony conviction for crimes involving violence, including rape, sexual assault, or homicide, but not assault and battery
	Felony conviction within the last five years for physical assault, battery or a drug or alcohol related offense
	Penal Code 220: assault with intent to commit to felony
	Penal Code 243.4: sexual battery
	Penal Code 264.1: rape
	Penal Code 273a(a): felony willful injury to a child (Penal Code 273(a), paragraph 1 prior to 1994)
	Penal Code 273ab: willful injury to a child 8 years of age or younger
	Penal Code 273d: corporal punishment to a child
	Penal Code 288: lewd acts with a child under 14
	Penal Code 289: forcible sexual penetration
	Penal Code Any crime listed on 290(c) – sex offender registry – EXCEPT Penal Code 261.5 (stat rape misdemeanor) & Penal Code 314 (indecent exposure misdemeanor)
	Felony charge for Penal Code 368: crimes against elders, dependent adults and persons with disabilities
	Any crime listed in Penal Code 667.5: enhancements for violent felonies
	Business and Professions Code 729: sexual misconduct by physician, therapist, etc.
	Penal Code 206: torture
	Penal Code 215: carjacking
	Penal Code 347(a): poisoning
Penal Code 417(b): brandishing a weapon around a school, daycare, etc.	
Penal Code 451(a): arson	
<b>CATEGORY 2: EXEMPTION AFTER INVESTIGATION HS §1522(g)(2)(B)(i-ii)</b>	Misdemeanor conviction within the last five years
	Felony conviction within the last 7 years
	Misdemeanor conviction for Penal Code 261.5: statutory rape
	Misdemeanor conviction for Penal Code 314: indecent exposure
	Misdemeanor conviction for Penal Code 368: financial abuse of elder
<p>May grant exemption if Department has substantial and convincing evidence to support a reasonable belief that the person is of present good character necessary to justify the granting of an exemption. <i>HS §1522 (g)(2)(B)</i></p> <p>Shall consider all reasonably available information, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Nature of the crime,</li> <li>• Period of time since the crime was committed,</li> <li>• Number of offenses,</li> <li>• Circumstances surrounding the commission of the crime indicating the likelihood of future criminal activity,</li> <li>• Activities since the conviction (including employment, participation in therapy, education or treatment),</li> <li>• Whether the person successfully completed probation or parole, obtained a certificate of rehabilitation or was pardoned,</li> <li>• Any character references or other evidence submitted by the applicant</li> <li>• Whether the person is demonstrating honesty and truthfulness concerning the crime during the application/approval process and made reasonable efforts to assist the Department in obtaining records and documents concerning the crime(s).</li> </ul> <p><i>HS §1522(g)(2)(C)</i></p>	
<b>CATEGORY 3: FAST- TRACK EXEMPTION HS §1522(g)(2)(D)</b>	Misdemeanor convictions not listed above that are older than 5 years old
	Felony convictions not listed above older that are than 7 years old
<p>Shall grant an exemption if the person’s state or federal criminal history information received from the DOJ independently supports a reasonable belief that the person is of present good character necessary to justify the granting of an exemption.</p> <p>However, the Department may at its discretion require an exemption after an investigation using the criteria in Category 2, as necessary to protect the health and safety of a child. <i>HS §1522(g)(2)(D)</i></p>	

# Emergency Placement vs. Compelling Reason

Emergency Placement (Relative/NREFM only)	Compelling Reason (May be anyone)
<p><b>Definition:</b> “Emergency placement” means a placement of a child or nonminor dependent (NMD) with a relative or nonrelative extended family member (NREFM<sup>1</sup>) prior to Resource Family Approval (RFA)<sup>2</sup> pursuant to Welfare and Institutions Code (WIC) section 361.4. (Effect. 1/1/18; current WIC §§ 309 &amp; 361.45)</p>	<p><b>Definition:</b> “Compelling Reason” means a decision to place a child with an applicant prior to approval as a Resource Family based upon the best interest of the child, to include maintaining a child’s family-like connections.</p>
<p><b>Differences: Background Check and Home Inspection</b> Prior to an Emergency Placement, a County:</p> <ol style="list-style-type: none"> <li>(1) Conducts a criminal background clearance check that includes a Child Abuse Central Index (CACI) and California Law Enforcement Telecommunications System (CLETS) for a relative or NREFM and adults residing in the home pursuant to WIC§ <a href="#">16504.5</a>. This is followed by a Live Scan (FBI, DOJ) within 10 calendar days after placement is made. CLETS is a name-based criminal check and could be inaccurate versus a Live Scan which is fingerprint based.</li> <li>(2) Conducts a brief home inspection which includes a County inspecting the home and grounds to determine that they are free of conditions that may pose an undue risk to health and safety of the child or NMD.</li> </ol>	<p><b>Differences: Background Check Assessment and Home Health and Safety Assessment</b> Prior to a Compelling Reason Placement:</p> <ol style="list-style-type: none"> <li>(1) RFA application has been received,</li> <li>(2) Home Health and Safety Assessment (as documented on RFA 03) has been completed and corrections have been made and</li> <li>(3) The background check assessment of the applicant and adults residing or regularly present in the home has been completed. This includes Live Scan, DMV, Megan’s Law Registered Sex Offered Check, and an Administrative Action Records System (AARS)<sup>3</sup> and Licensing Information System (LIS)<sup>4</sup> checks, and if applicable, criminal record exemptions and clearances based on investigations for serious arrests.</li> </ol>
<p><b>Requirements SECTION 7-01: Emergency Placement with Relative or NREFM</b></p> <ul style="list-style-type: none"> <li>▪ Within 5 business days after a child or NMD is temporarily placed with a relative or NREFM, a County shall: <ul style="list-style-type: none"> <li>○ Discuss funding options available to a relative or NREFM</li> <li>○ Provide a relative with a blank copy of form CW 2218 “Rights, Responsibilities and Other Important Information” and form CW 2219 “Application for California Work Opportunity and Responsibility to Kids (CalWORKs)” for all eligible children temporarily placed with the relative.<sup>5</sup> (Best Practice tips: Assist the family with completing the application). NREFMs are not eligible for a CalWORKs payment on behalf of the child in this situation.</li> </ul> </li> </ul>	<p><b>Requirements SECTION 7-02: Placement Based on Compelling Reason</b></p> <ul style="list-style-type: none"> <li>▪ Complete the Permanency Assessment and prepare the Written Report within 90 calendar days of the date a child or NMD was temporarily placed with the applicant, unless good cause exists. If good cause exists, a County shall document the reasons for the delay and generate a timeframe for completion.</li> <li>❖ An applicant is not eligible to receive an AFDC-FC or state foster care payment until the applicant is approved as a Resource Family and the child or NMD meets all other eligibility criteria. The temporary placement of a child or NMD with an applicant pursuant to this section does not ensure approval as a Resource Family.</li> </ul>

<sup>1</sup> See [ACIN I-39-15](#) for information regarding expansion of NREFM definition.

<sup>2</sup> Reference: [RFA Written Directives Version 4.1](#)

<sup>3</sup> A check for prior licensing-related administrative actions contained in the Administrative Action Records System (AARS) database maintained by the Department, and a check for prior Resource Family-related administrative actions contained in the AARS and Notice of Action databases maintained by the Department.

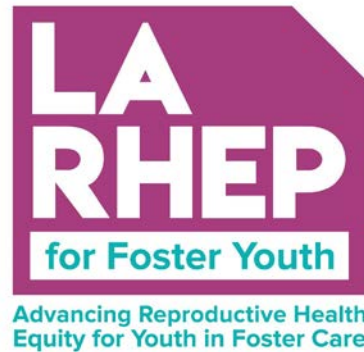
<sup>4</sup> A check for prior licensing history and criminal record exemption denial or rescission actions contained in the Licensing Information System (LIS) database maintained by the Department.

<sup>5</sup> See [ACL 16-45](#)

## Emergency Placement vs. Compelling Reason

- Begin the RFA process with the applicant which includes submission of the RFA Application and a Comprehensive Assessment of the family. The Comprehensive Assessment includes the Home Health and Safety Assessment (including the background checks), and Permanency Assessment. The Comprehensive Assessment and the Written Report will be completed within 90 calendar days of the date a child or NMD was temporarily placed with the applicant, unless good cause exists. If good cause exists, a County shall document the reasons for the delay and generate a timeframe for completion.
  
- ❖ An applicant is not eligible to receive an AFDC-FC or an ARC payment until the applicant is approved as a Resource Family and the child or NMD meets all other eligibility criteria. The temporary placement of a child or NMD with an applicant pursuant to this section does not ensure approval as a Resource Family.

# Supporting the Healthy Sexual Development of Youth





# Test Yourself: Which is myth and which is fact?

1. Caseworkers must provide foster youth with age appropriate information on sexual and reproductive health annually, starting at age 10. **M/F**
2. Youth under age 12 have a right to obtain and use contraception confidentially. **M/F**
3. Youth 12 and older have a right to obtain and use condoms confidentially. **M/F**
4. It is illegal for a CASA to speak to a foster youth regarding STI's and safe sex without first obtaining parent or caseworker permission. **M/F**
5. Foster parents have a duty to inform child welfare if a youth requests transportation to an abortion appointment. **M/F**

# Agenda for Presentation

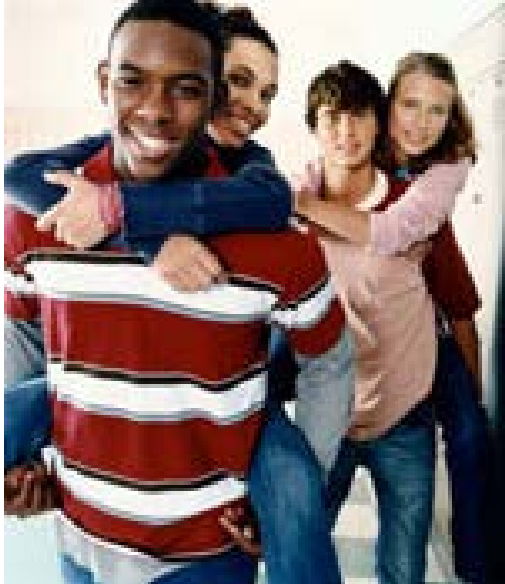
1. Framing and context
2. Overview of contraceptive methods and available sexual and reproductive health programs and referrals
3. Rights of youth in care
4. Obligations of case workers and caregivers
5. Communicating with youth about sexual health
6. Confidentiality and documentation
7. Role of attorneys and judges

# Normal Development:

Easy to appreciate developmental role of these activities



# Is this normal development?



# Romantic Relationships are Normal

- Identity formation and validation
- Social competencies learned and tested
  - Training in intimacy, mutual affirmation, communication, negotiation
- Healthy relationships have to be learned
  - Foster youth may have had little or no exposure to healthy relationships or have themselves been victims of sexual, physical and emotional abuse in their intimate and familial relationships

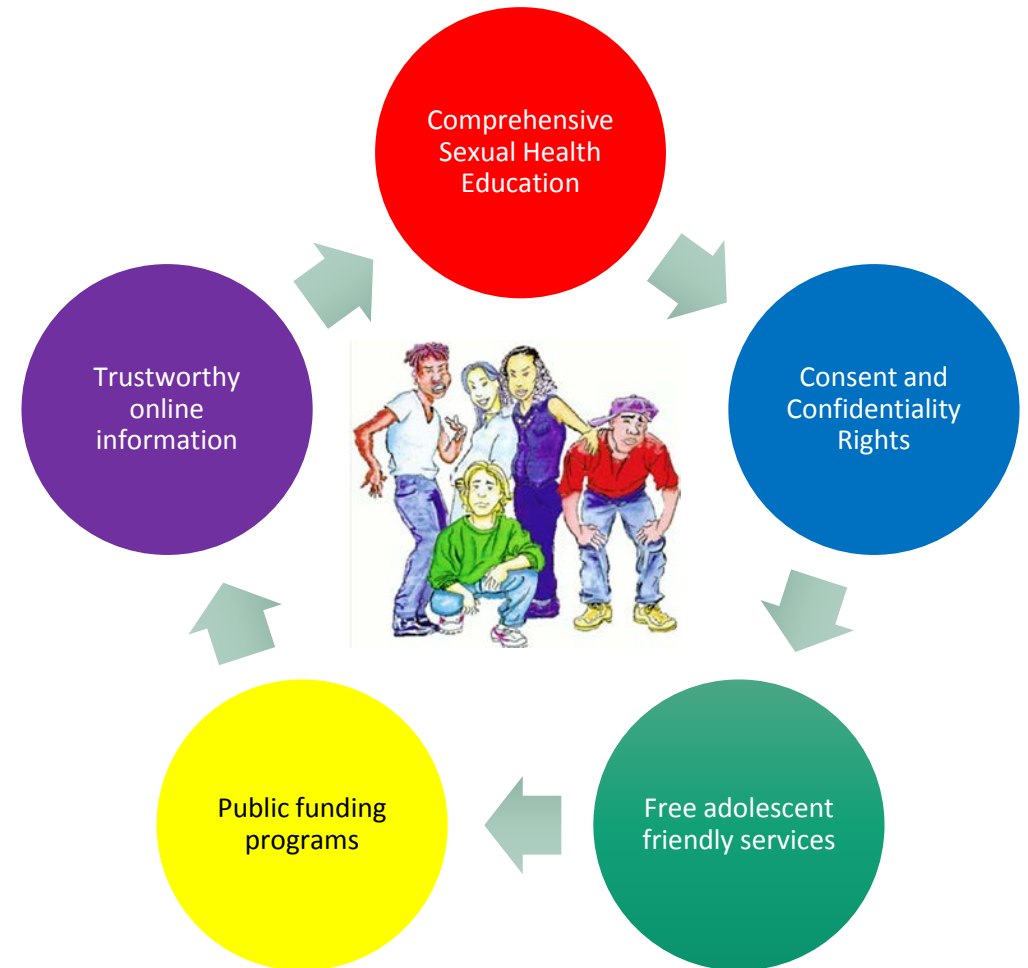
# Adolescent Sexual Development-Stages

STAGE	FACTS
<b>Early Adolescence</b>  Females: 9-13 years old Males: 11-15 years old	<ul style="list-style-type: none"><li>• Puberty/concern with body changes and privacy</li><li>• Development of first crush</li><li>• Sexual fantasies common</li><li>• Sexual intercourse not common before age 13</li></ul>
<b>Middle Adolescence</b>  Females: 13-16 years old Males: 15-17 years old	<ul style="list-style-type: none"><li>• Increasing concern with appearance</li><li>• Peer influence strong</li><li>• Dating/Experimentation with relationships and sexual behavior common</li><li>• Sexual behavior doesn't always match orientation</li></ul>
<b>Late Adolescence</b>  Females: 16-21 years old Males: 17-21 years olds	<ul style="list-style-type: none"><li>• Firmer and more cohesive sense identity</li><li>• Ability to establish mutual trusting relationships</li><li>• More abstract thinking</li></ul>

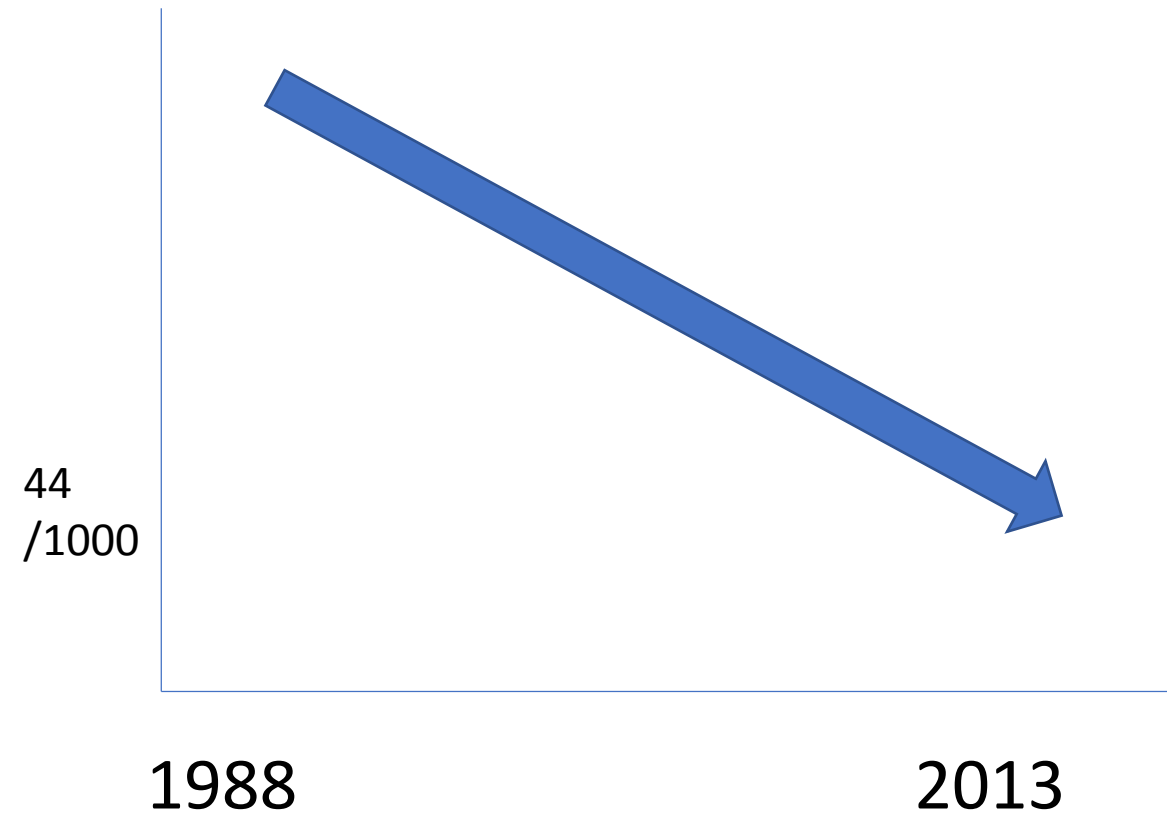
# California has grown a rich network of sexual and reproductive health information and services to address adolescent needs

## Highlights:

- Mandatory comprehensive sexual health education in public middle and high schools
- Consent rights that allow adolescents who need it to confidentially access care
- A network of clinics, specially trained to address adolescent needs
- Public funding streams for sexual health services to ensure free access
- State agencies coordinating coverage, and
- Trustworthy information for teens and adult caregivers



# Services and programs have effectively reduced pregnancy for teens overall



Teen birth rate in CA down **77%** since 1991

**Greatest** percent reduction in US, along with CT and MA

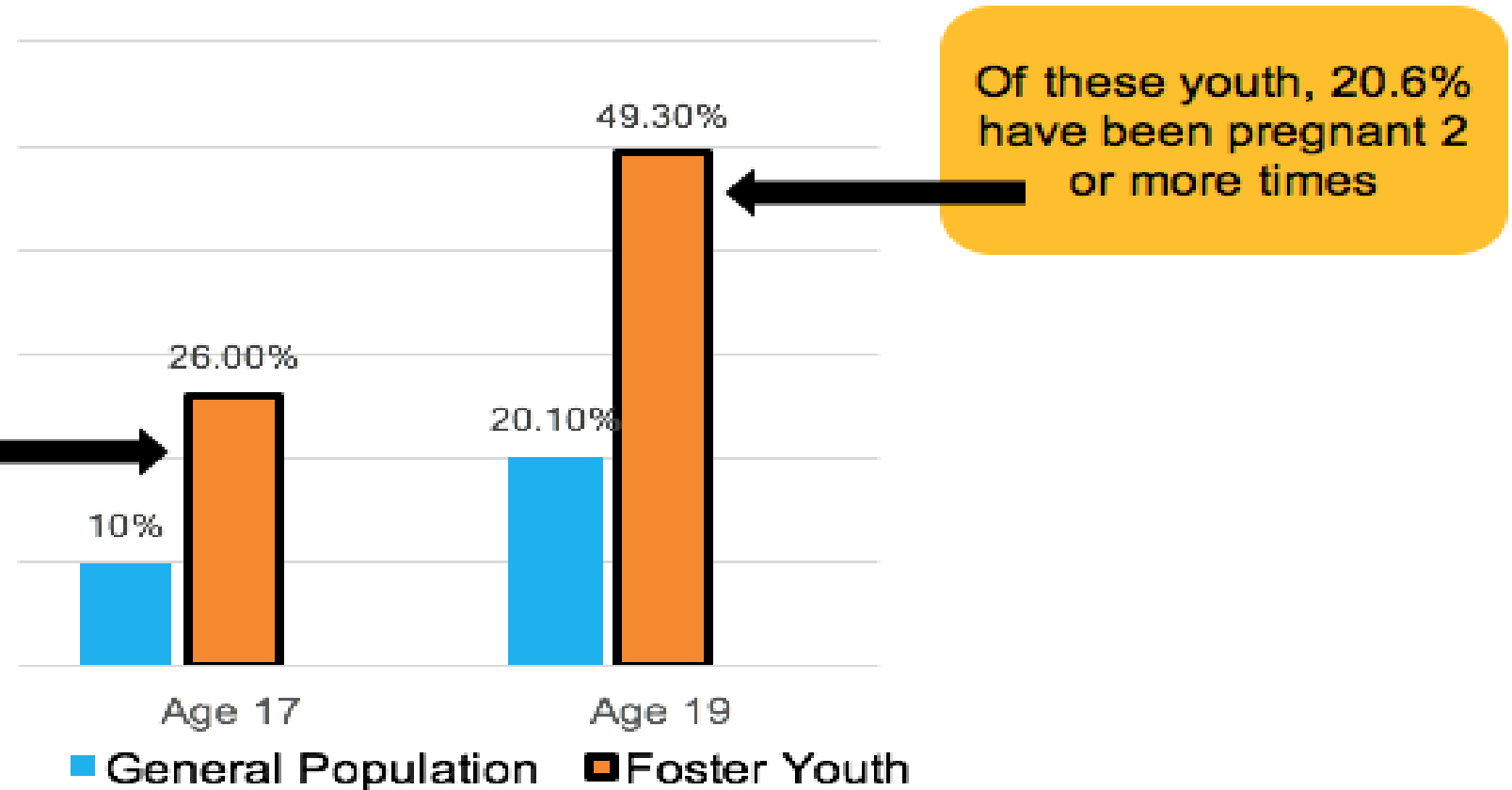
<https://powertodecide.org/what-we-do/information/national-state-data/california>

<https://powertodecide.org/what-we-do/information/national-state-data/change-teen-birth-rate>



# Yet, almost 50% of females in foster care in CA will have been pregnant at least once by age 19

Pregnancy Rate of Youth



Source: Courtney et al., Findings from the California Youth Transitions to Adulthood Study: Conditions at Age 17 and at Age 19 (2014, 2016).

# Are these pregnancies intended?



Young women in foster care at age 17:

Wanted to become pregnant:	%
Definitely no	30%
Probably no	14%
Neither wanted nor didn't want	26%
Probably yes	18%
Definitely yes	7%

70%

24.3% report using contraception at last pregnancy



Young men in foster care at age 17:

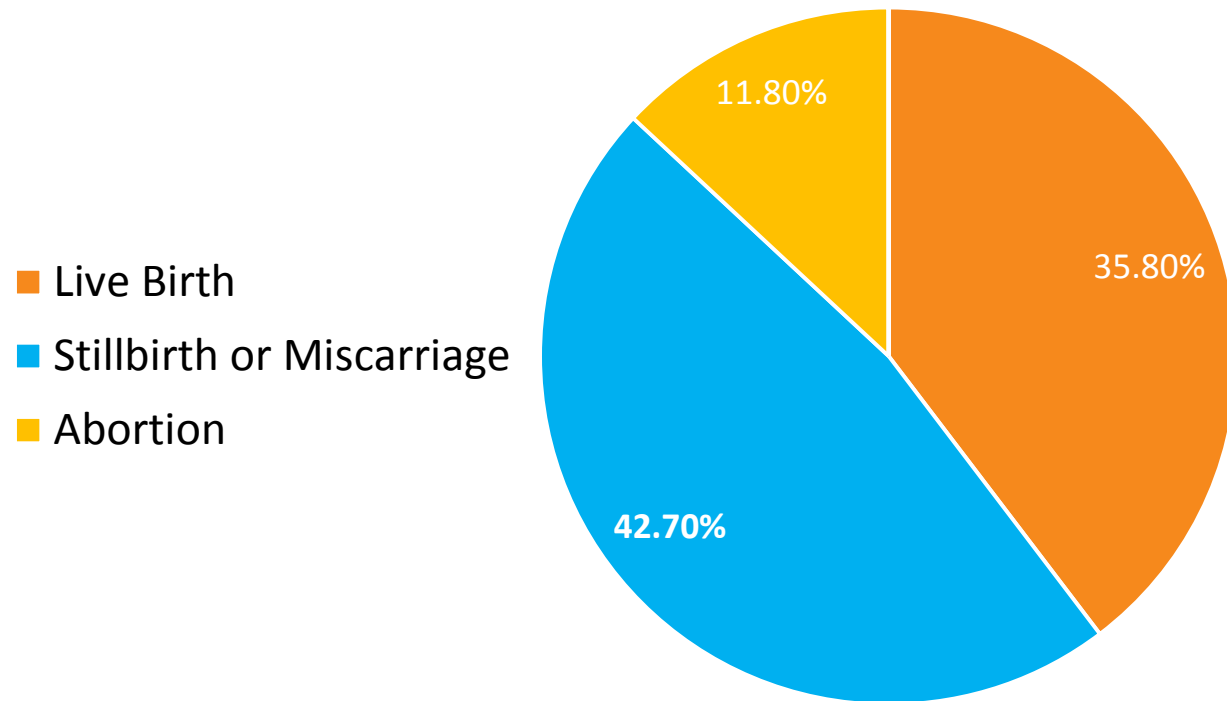
Wanted partner to become pregnant:	%
Definitely no	31.8%
Probably no	11.7%
Neither wanted nor didn't want	23.1%
Probably yes	16.5%
Definitely yes	8.7%

66.6%

23.% report using contraception at last pregnancy

# Prenatal Care & Pregnancy Outcomes

Of foster youth surveyed at 17 who reported pregnancy:



**42%** report miscarriage or stillbirth. Miscarriage rate for females age 15-19 in US in 2010 was just **15 percent**.

**20.7%** of foster youth never received prenatal care

# What are the implications of unintended pregnancy and the related outcomes among foster youth?



At age 19, of those who had not enrolled in higher education, 30% cited the need to care for children as a major barrier to returning to school.



Economic costs to youth & child welfare system.



Children born to foster youth were 3 times more likely to have a substantiated report of maltreatment by age 5 than children born to the same-age youth in the general population.

# Why don't intentions and reality always align?



**Remember to ask yourself...**

- What is in the youth's power and control?
- What is in the youth's sphere of influence?



**Power and  
Control?  
Influences?**

# Foster Youth Face Unique Barriers

Lack of policies and training lead to fear, confusion about reproductive rights & responsibilities

Inconsistent access to comprehensive sexual health education & contraception

Practices that actively infringe on youth rights

Logistical and Structural barriers & provider bias

## Youth on barriers:

“Staff would search our rooms, and if they found condoms they would take them away and you would get in trouble.”

“My house manager . . . tried to pressure me into getting an abortion. She set up an appointment at Planned Parenthood for me to get an abortion and drove me there.”

“I had to ask [the group home staff] to make me an appointment because the group home knew where we were supposed to be all the time and controlled all the transportation.

I was not allowed to make doctor’s appointments for myself.”

## Youth and Caregivers communication:

“None of my foster parents—I had 14 placements—ever brought up the issue; they were able to establish a curfew and don’t do this and don’t do that, but never a sit down, one-on-one talk.”

“My foster parents were very religious and told me not to have sex, that it’s a sin and I’d go to hell.”

“I was just thinking that if a kid is in foster care and the child is to reunify with the parents, who are we to talk to their kids about sexuality?”



## Caseworkers on lack of training:

“I don’t know how far we can go into a conversation; I avoid certain topics.”

“I was just pulling things from out of the air because I really didn’t know what was available to her.”

“I didn’t ask a pregnant teen whether she was getting prenatal care or any other questions; it was beyond my comfort level; I don’t know what they are thinking; I just keep focus on ILP stuff, bus pass, workshops...”

# Foster Youth Face Unique Circumstances and Risks

STAGE	General Population Facts	Things to know about youth in care
<b>Early Adolescence</b>	<ul style="list-style-type: none"> <li>• Puberty/concern with body changes and privacy</li> <li>• Development of first crush</li> <li>• Sexual intercourse not common before age 13</li> </ul>	<ul style="list-style-type: none"> <li>• Youth who have experienced trauma may <b>enter puberty up to a year earlier</b> than peers.</li> <li>• Twice as likely to identify as <b>LGBTQ</b></li> </ul>
<b>Middle Adolescence</b>	<ul style="list-style-type: none"> <li>• Dating/Experimentation with relationships and sexual behavior common</li> <li>• 27% 15-17 year olds have had sex</li> <li>• 11% report forced sex before age 19</li> </ul>	<ul style="list-style-type: none"> <li>• About 20% of female foster youth and 7% of males report sexual molestation while in care</li> <li>• <b>49% report forced sex</b> at some point before age 19</li> <li>• 52% foster youth ages 15-17 report having had sex</li> </ul>
<b>Late Adolescence</b>	<ul style="list-style-type: none"> <li>• Ability to establish mutual trusting relationships</li> </ul>	<ul style="list-style-type: none"> <li>• The <b>majority of sexually trafficked youth</b> are involved in child welfare</li> <li>• Over <b>90%</b> of foster youth are <b>youth of color</b>. Many youth face intersectional bias and discrimination.</li> </ul>

# Keys to Healthy Decision-Making and Making Decisions Reality: Relationships, Knowledge, Motivation and Access

1. Supportive **relationships** between the youth and a caring **trusted adult**.
2. Comprehensive, **accurate information** from reliable sources about healthy relationships, safety, sex, reproductive health, pregnancy and contraception.
3. Motivation to make careful decisions is tied to the ability to envision a **bright future**.
4. Access to **tools and services** that allow them to realize their decisions

# New Tools and Rules

- CDSS Healthy Sexual Development Project (begun in 2016)
  - <http://www.cdss.ca.gov/inforesources/Foster-Care/Healthy-Sexual-Development-Project>
- Series of ACLs and Guidance issued by CDSS
- New legislation – CA Senate Bill 89 (2017)

# Why it matters:

**Victoria's Story\***

**Belinda's Story\***

\* Names and certain details changed to protect confidentiality

# Overview of Contraception and Sexual and Reproductive Health Services and Referrals

*“Things have changed since I was young.”*  
–foster parent

# Lots of Contraceptive Options



Photo from [www.BedSider.org/Methods](http://www.BedSider.org/Methods) (c) LA Health and the Health Equity Project for Foster Youth

# Not your Grandma's birth control

## Types of Birth Control:

- Barrier
- Hormonal
- Long Acting Reversible (LARC)
- Emergency Contraception
- Other Methods

## Considerations in Selection:

- Duration
- Ability to hide use
- STD prevention
- Availability
- Comfort

*Important for a youth to work with health provider to determine what is right for them*

“Youth should be asked, What do you want, and need? Some youth are pressured to have a shot. We need background support. Need to know more about sexual health. Youth need to have a voice, and not just be pushed around.” –youth in care



# Broad Insurance Coverage

## Birth Control for Teens

- Public and private insurance must pay for ALL METHODS.
- Must be free, no co-pays.
- Can request 12 month supply of pills, patches and rings at one time
- Free CONDOMS for teens through **Condom Access Project** via [www.teensource.org](http://www.teensource.org)



# A Network of Free Sexual and Reproductive Health Services in California

Three federal and state public programs weave together to mean a full range of sexual and reproductive health services are available all over California and at no cost to adolescents:

- MediCal (AAP's Bright Futures standard of care)
- Title X (administered by Essential Access Health in California)
- Family PACT (administered through California Office of Family Planning)

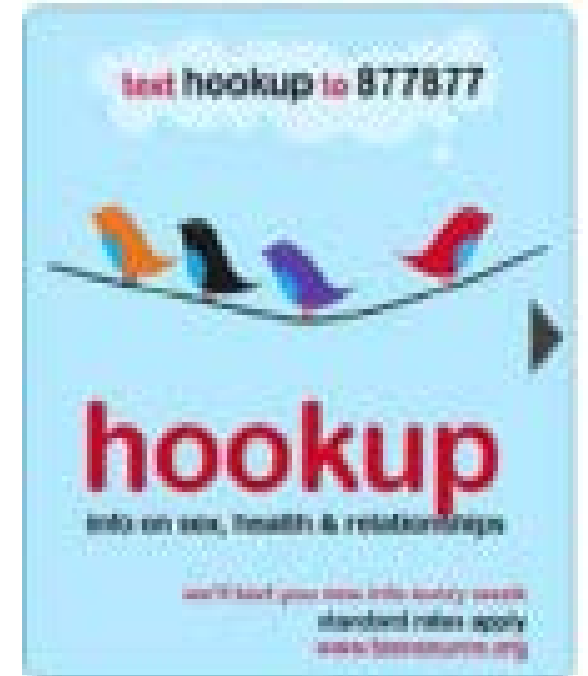
# This network means...

## STD screening, Prenatal and Abortion for Teens

- Insurance must pay.
- No co-pay in Medi-Cal.
- **No-cost access to PrEP** (pre-exposure medication to reduce risk of HIV infection)
- Confidential, teen controls access to own info

## Sexual health education and guidance

- Federal and state funding pays for online resources
- Anticipatory guidance from health provider is part of Medi-Cal standard of care for annual appointments
- State law requires public schools to provide comprehensive medically accurate sexual health education at least once in middle and once in high school



# This network means...

## Many providers

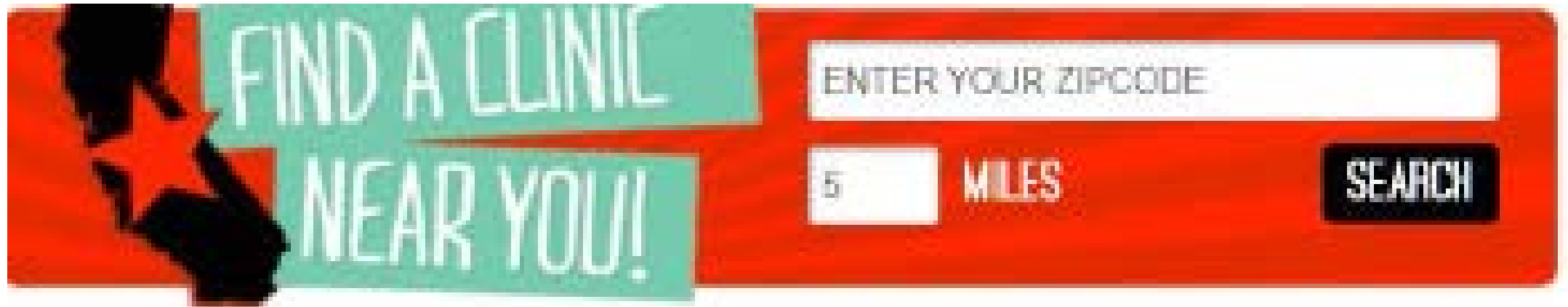
- Can go to Medi-Cal doctor of choice. Bright Futures recommends confidential time to discuss sexuality and risk reduction. Also funds time for anticipatory guidance.
- Out of network provider of choice, including any of the Family PACT clinics
- **Over 2,200 public and private FPACT providers**



# Where to find services and clinic referrals?

In addition to a youth's own Medi-Cal provider, there are over **2,200 public and private clinics**, health centers, and providers across the state with FamilyPACT and Title X funding to support access to free confidential sexual and reproductive health care and information for adolescents.

**[www.TeenSource.org](http://www.TeenSource.org)**



# Where to find reliable information & training?

[www.TeenSource.org](http://www.TeenSource.org) for youth friendly information (Essential Health Access)

[TalkWithYourKids.org](http://TalkWithYourKids.org) for caring adults (Essential Health Access)

[Learning Exchange](http://LearningExchange) for professionals (Essential Health Access)

[www.Bedsider.org/methods](http://www.Bedsider.org/methods) for young people (Power to Decide)

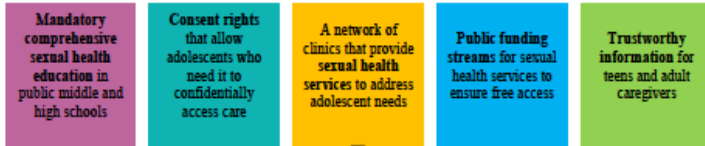
[Sexual Health Educator \(SHE\) Training Program](#) (CA Department of Public Health, STD Control Branch)

# Slide content is available as handouts:



## California Sexual and Reproductive Health Care Services

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents. These include:



In California, the availability of three different public funding programs means that a full range of sexual and reproductive health services is available to adolescents at no cost.

### Birth Control for Adolescents

- Public and private insurance must pay for all methods of birth control, including emergency contraception
- Birth control must be free (no co-pays)
- Adolescents can request a 12-month supply of pills, patches, and rings at one time
- Free condoms for adolescents through the Condom Access Project
  - Youth can request free condoms or find locations to pick them up at: [www.teensource.org/condoms/free](http://www.teensource.org/condoms/free)
- Minors of all ages have a right to consent to and to confidentiality in services.

### STI Screening and Services for Adolescents

- Most public and private insurance must pay for recommended screening and prevention with no co-pay, including the HPV and Hepatitis B vaccines.
- STI screening and services as available with no co-pays.
- Free condoms for adolescents through the Condom Access Project. Information at: <http://www.teensource.org/condoms/free>
- Medi-Cal Minor Consent covers PrEP for minors with no co-pay. PrEP is a pre-exposure prophylactic medication that reduces the risk of HIV infection.
- Minors 12 and older have a right to consent to and to confidentiality in services.

### Pregnancy Testing, Prenatal Care and Abortion for Adolescents

- Testing and services with no co-pay
- Medi-Cal covers prenatal, postnatal, abortion and related services, such as ultrasound, with no co-pay.
- Insurance must ensure timely access to providers.
- Minors of all ages have a right to consent to and to confidentiality in services.

Teens can find sexual and reproductive health clinic referrals, including referrals for no-cost care at: <http://www.teensource.org/find-a-clinic>

Sources: NH&P, Reproductive Coverage in Medi-Cal, at <http://www.healthlaw.org/storage/documents/NH&P-Report-NC-Medi-Cal-Web-F.pdf>; Access and NH&P, California Abortion Coverage in Medi-Cal and Private Insurance, at <http://accessn.org/files/infch/Files/docs/NH&P-CAAbortionCoverageandNH&P-Web.pdf>; KFF, Payment and Coverage for the Prevention of Sexually Transmitted Infections, at <https://www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-sti>

[www.fosterreprohealth.org](http://www.fosterreprohealth.org) (2018)



## California Sexual and Reproductive Health Care Information

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents. These include:



There are many resources for adolescents and adult caregivers regarding sexual and reproductive health care. Federal and state funding pays for online resources, including content from state agencies and Essential Access Health, the agency that administers federal Title X funding in California.

### Resources from Essential Access Health

- [www.teensource.org](http://www.teensource.org)
  - Clinic referral tool
  - Youth-friendly information on birth control, STIs, relationships, and rights under California law
- Text messaging service called "The Hookup" provides weekly sexual health information. Texting a zip code to the service will identify a nearby clinic that can provide low to no cost sexual health services.
  - More information at: <http://www.teensource.org/hookup>
- [www.talkwithyourkids.org](http://www.talkwithyourkids.org)
  - Information for caring adults on how to talk with teens about sexual health care and healthy relationships
- <https://www.essentialaccess.org/learning-exchange>
  - National resource for health professional in primary care, private practice, family planning and women's health settings seeking to learn and share best practices in sexual and reproductive health care service delivery

### State Resources

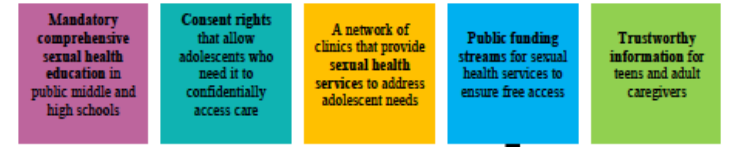
- <http://www.familynact.org/clients/education-materials>
  - Education materials for patients on birth control methods, STIs, reproductive coercion and intimate partner violence, and breast and cervical cancer screening
- <https://www.cdph.ca.gov/Programs/CH/D/DMCAH/CDPH%20Document%20Library/Communications/Profile-IE.pdf>
  - In-person information and education programs from the California Department of Public Health
- <http://californiapct.com/sexual-health-educator-training-program/>
  - Free training program for educators in school, community, and clinic settings who want to build their knowledge and capacity in sexual health and sexuality education
  - In-person and online training topics include: STD/HIV review, contraceptive methods, minor consent and confidentiality, STD data, California education code, and more

[www.fosterreprohealth.org](http://www.fosterreprohealth.org) (2018)



## California Sexual and Reproductive Health Care Programs

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents. These include:



In California, the availability of three different public funding programs means that a full range of sexual and reproductive health services is available to adolescents at no cost.



### Medi-Cal

**Standard of Care:** California has adopted the AAP Bright Futures Guidelines as the standard of care in the state Medi-Cal program. Bright Futures recommends the following:

- Requires annual health visits for teens
- Recommends confidential time with the provider at each health maintenance visit to discuss sexuality, sexual health promotion, and risk reduction
- Includes coverage for anticipatory guidance, referrals and follow ups for sexual health as necessary



### Covered Services:

- When services are necessary, Medi-Cal covers confidential family planning, prenatal care, abortion, and STI services for adolescents for free with no co-pays.

### Provider Choice:

- Federal Medicaid regulations, which apply to California's Medi-Cal program, allow patients to choose their provider of choice for sexual and reproductive health care (i.e. they are not required to see primary care physician for these services if they prefer another provider).
- There is no need for referral from primary care – patients can go directly to a sexual and reproductive health specialist for care.

For more information on Bright Futures: <https://brightfutures.aap.org/states-and-communities/Pages/California.aspx>  
For more information on Medi-Cal: NH&P, Reproductive Health Care Coverage in Medi-Cal, <http://www.healthlaw.org/storage/documents/NH&P-Report-NC-Medi-Cal-Web-F.pdf>

### Family PACT

The California Office of Family Planning (OFP) is charged by the California Legislature "to make available to citizens of the State who are of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families".

- The OFP administers the Family Planning, Access, Care, and Treatment (Family PACT) program. Family PACT is California's innovative approach to provide comprehensive



[www.fosterreprohealth.org](http://www.fosterreprohealth.org) (2018)

# **Rights of Youth in Care Related to Sexual and Reproductive Health**



# Case: Residential Facility

A residential facility sends 4 young women to a clinic for their health check up. They are accompanied by a staff person. The staff person states that all the girls need an IUD because new protocol is to encourage use of LARC (long-acting reversible contraceptive).

The staffer shows the front desk paperwork that clearly states the facility has been given care, custody and control of the youth and that consent for health care has been signed over to them.

**Who consents for an IUD?**

# Children & Youth in Foster Care Share the Same Reproductive Rights as all Californians



The right to consent to or decline medical care (without need for consent from a parent, caregiver, guardian, social worker, probation officer or the court) for

1. The prevention or treatment of pregnancy, including contraception, at any age (except sterilization)
2. An abortion, at any age
3. Diagnosis and treatment of sexual assault, at any age
4. The prevention, diagnosis, and treatment of STIs and HIV, at age 12 or older

*All rights are listed with legal and regulatory citations in ACL 16-82*

(c) LA Reproductive Health Equity Project for Foster Youth

## Case: Inez

Inez is a fourteen year-old youth in foster care. Her foster parent brings her to her regularly scheduled doctor's visit. When Inez is called into the exam room, her foster mom joins her.

The provider explains that every youth receives a few minutes alone with the provider and that the provider will be asking foster mom to step outside in a little bit. Foster mom says that she is required to be with Inez at all times and that she will not leave.

**What are Inez's rights to care?**

# Children & Youth in Foster Care Share the Same Reproductive Rights as all Californians



The right to patient **confidentiality** regarding medical services and records including those listed *on previous slide* unless there is written consent to disclosure or through court order.



The right to **privacy for examination** or treatment by a medical provider, unless the youth specifically requests otherwise.

*All rights are listed with legal and regulatory citations in ACL 16-82*

## Case: Inez

After the provider explains the importance of private time for Inez, Inez's foster mom does agree to step out. Inez expresses interest in birth control.

The provider explains that Inez can get contraception on her own, but, if she got a prescription, the doctor would have to tell Inez's foster parent and include this information in the paperwork that goes back to child welfare. Inez says "Never mind then."

**What are Inez's rights to confidentiality?**

# Children & Youth in Foster Care Share the Same Reproductive Rights as all Californians



## What does the right to confidentiality mean?

- If youth receives reproductive and sexual health services and/or asks questions about sex, contraception or other related topics during a health appointment, ***the provider cannot share with the youth's parents, caregivers, group home, social worker, probation officer or others without the youth's written consent.***
- Youth may ask their doctor before receiving care if the doctor will maintain confidentiality.
- Youth has the right to withhold consent to disclosure.

*All rights are listed with legal and regulatory citations in ACL 16-82*

*All children and youth in California have these rights- even yours! Foster youth don't "lose them" when they become dependents*

<b>California Minor Consent Laws</b>			
Who can consent for what services and provider's obligations			
	Minor Consent Sufficient for Confidential Care	Parent/Guardian Consent Required	Parent/Guardian Notification Required
Abortion	Yes	No	Not allowed without consent of minor
Birth Control	Yes (except sterilization)	No (except sterilization)	
Pregnancy (Prev., Dx & TX)	Yes <sup>1</sup>	No <sup>1</sup>	
STD's, Contagious & Reportable Diseases (Dx & Tx)	Yes (minors ≥12 years)	Not needed for minors ≥12 years	
HIV Testing	Yes (minors ≥12 years and assessed as competent to give informed consent)	Not Needed for minors ≥12 years, unless deemed incompetent to consent	
Outpatient Mental Health Treatment	Yes <sup>2</sup> (minors ≥12 years)	Yes (except <sup>2</sup> )	An attempt should be made, except when the provider believes it is inappropriate
Alcohol/Drug Abuse Treatment	Yes (minors ≥12 years)	Not needed for minors ≥12 years, except for methadone treatment <sup>1,3</sup>	Not allowed without consent of minor
Rape <sup>4</sup>	Yes (minors ≥12 years)	Not Needed <sup>1</sup> for minors ≥12 years	
Sexual Assault <sup>5</sup>	Yes	No	An attempt must be made except when provider believes parent or guardian was responsible

<sup>1</sup> Including inpatient Care

<sup>2</sup> If (1) the minor is ≥12 years, is mature enough to consent AND (2) the minor is (A) the victim of incest or child abuse or (B) would present a threat of serious physical or mental harm to self or others without treatment

<sup>3</sup> However, parents can consent over the child's objection

<sup>4</sup> Non-consensual sexual intercourse

<sup>5</sup> Acts of rape, oral copulation, sodomy, and other violent crimes of a sexual nature

## Case: Inez

Back home, Inez asked her foster parent to drive her to Planned Parenthood. Her foster mom said that she doesn't believe in Planned Parenthood and house rules are no contraception.

**What are Inez's rights to care?**



# Children and Youth in Foster Care also Have Special Rights



The right to have access to age-appropriate, medically accurate **information** about

- reproductive and sexual health care,
- the prevention of unplanned pregnancy including abstinence and contraception,
- abortion care,
- pregnancy services, and
- the prevention, diagnosis, and treatment of STIs, including but not limited to the availability of the Human Papillomavirus (HPV) vaccination.

*All rights are listed with legal and regulatory citations in ACL 16-82*

# Children and Youth in Foster Care also Have Special Rights



The right to be provided transportation to reproductive and sexual health related services.

- *“Many reproductive health services are time-sensitive (e.g. emergency contraception, abortion); therefore, transportation must be provided in a timely manner in order to meet the requirement.”*



The right to obtain, possess and use the contraception of their choice, including condoms

- *“Group home and short-term residential therapeutic program (STRTP) staff may not confiscate a youth’s contraception as part of its disciplinary program.”*

*All rights are listed with legal and regulatory citations in ACL 16-82*

# Children and Youth in Foster Care also Have Special Rights



The right to have private storage space and to be free from unreasonable searches of his or her personal belongings.



The right to receive medical services and to choose his or her own health care provider



The right to independently contact state agencies... regarding violations of rights...to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints

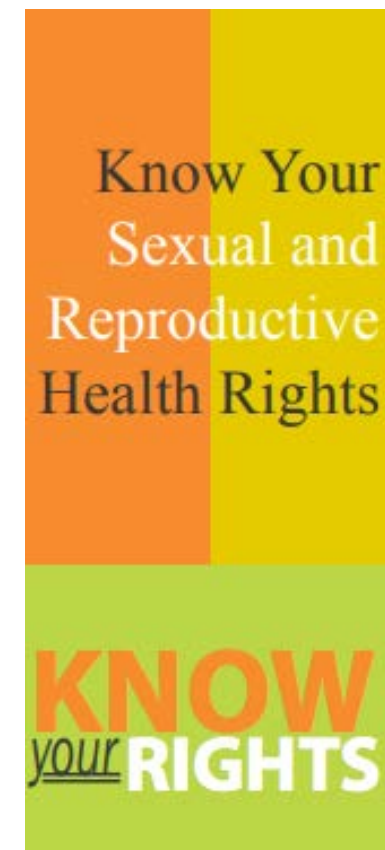
*All rights are listed with legal and regulatory citations in ACL 16-82*


# Handouts available online:

1. **CDSS All-County Letter 16-82** (Reproductive and Sexual Health Care and Related Rights for Youth and NMDs), available on CDSS’s Healthy Sexual Development website

2. **CDSS “Know Your Rights” youth brochure**, available on CDSS’s Healthy Sexual Development website

3. **Sexual and Reproductive Health Care for Foster Youth: Minor Consent Law in California**, available at [www.TeenHealthLaw.org](http://www.TeenHealthLaw.org)



 **Sexual and Reproductive Health Care for Foster Youth: Minor Consent Law in California**

FOSTER YOUTH OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A SOCIAL WORKER OR CAREGIVER ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
<b>PREGNANCY</b>	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 4925).	The health care provider is not permitted to inform a social worker or caregiver without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
<b>CONTRACEPTION</b>	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 4925).	The health care provider is not permitted to inform a social worker or caregiver without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. ( <i>American Academy of Pediatrics v. Langren, 16 Cal.4<sup>th</sup> 307 (1997)</i> ; Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
<b>ABORTION</b>	A minor may consent to an abortion. (Cal. Family Code § 4925; <i>American Academy of Pediatrics v. Langren, 16 Cal.4<sup>th</sup> 307 (1997)</i> ).	The health care provider must attempt to contact the minor's guardian and note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 4925).
<b>SEXUAL ASSAULT<sup>1</sup> SERVICES AND RAPE<sup>2</sup> SERVICES FOR MINORS UNDER 12 YRS<sup>3</sup></b>	"A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis, ... treatment and the collection of medical evidence with regard to the ... assault." (Cal. Family Code § 4928).	Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters following mandated reporting procedures. Reporting to a youth's child welfare case worker does not satisfy this obligation. (See Cal. Penal § 11167 and 11167.5.)

<sup>1</sup>Rape is defined in Cal. Penal Code § 261.  
<sup>2</sup>See also "Rape Services for Minors 12 and Over" on page 3 of this chart.  
<sup>3</sup>In the presence of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.

# Obligations of Caseworkers and Caregivers to Support Healthy Sexual Development

*Source:* CDSS, A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention (2017); CDSS ACL 16-88; Welfare and Institutions Code 16501.1(g)(20),(21)

# Required Responsibilities of Child Welfare and Probation Caseworkers in five broad categories



Informing and providing information



Ensuring access to services



Ensuring personal biases are not imposed upon foster youth

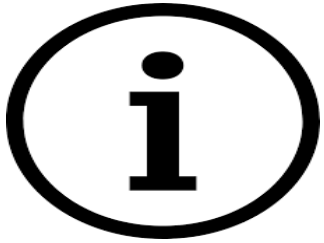


Documenting



Respecting Confidentiality

# Required Responsibilities of Caseworkers



**Inform** youth of their rights upon entry into foster care and at least once every six months

- “...ensuring the youth understands their rights based on their age and developmental level.”



Provide **access** to age-appropriate medically-accurate, and culturally sensitive information about all of the following:

- Sexual development
- Reproductive and sexual health care
- The prevention of unplanned pregnancies
- Use of birth control
- Abortion
- The prevention and treatment of sexually transmitted infections (STIs)

# Required Responsibilities of Caseworkers



Inform foster youth of their right to consent to sexual & reproductive health care

Inform foster youth of their rights to confidentiality



Seek youth's written consent prior to any disclosure of sexual health information



Ensure barriers to services are addressed in a timely and effective manner

Ensure youth are up-to-date on their annual medical appointments



Ensure personal biases and/or religious beliefs are not imposed upon foster youth



# Required Responsibilities of Caseworkers:\*



SHALL **DOCUMENT IN THE CASE PLAN** on an annual basis, for all youth and NMDs ages 10 and older:

- That youth has received comprehensive sexual health education in middle or high school or agency has plan to provide it
- That worker has informed the youth or young adult
  - that he or she may access information about reproductive and sexual health care.
  - of his or her right to consent and confidentiality rights regarding those services, in an age- and developmentally appropriate manner,
  - how to access reproductive and sexual health care services
- That worker has facilitated access to that care, including by assisting with any identified barriers to care, as needed

Citation: CDSS ACL 16-88 and Welfare and Institutions Code 16501.1(g)(20),(21)

\* **New obligations as of July 2017**

# Caseworkers Must Ensure Barriers to Services Are Addressed in a Timely and Effective Manner



## **Implementation Guidance from CDSS:**

- Ask foster youth if they are facing barriers to health care, including desired sexual or reproductive health care services or treatment
- May initiate conversation during monthly contacts and when informing of foster and sexual and reproductive health rights every six months.
- If learn of barriers, must address in a timely and effective manner

# Addressing barriers to care



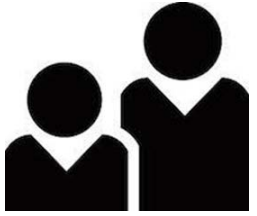
## **Some examples of typical barriers the youth have faced:**

- Youth is unaware of their insurance information or doesn't have a copy of his/her medical card
- Youth doesn't know how to schedule a sexual health doctor's appointment or is too embarrassed
- Youth doesn't have transportation to a medical appointment
- Youth reports that placement prohibits or confiscates contraception
- Youth reports that placement refuses to let youth seek sexual health care at preferred provider
- Regular care provider doesn't feel trustworthy to youth

# Additional Resources:

- CDSS, “**A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention**” (2017), available on CDSS Healthy Sexual Development website
- CDSS **All-County Letter 16-88**, available on CDSS Healthy Sexual Development website
- Forthcoming **all-county letter on SB 89** with information on case plan documentation requirements and connecting youth to education that complies with California Healthy Youth Act

# Required Responsibilities of Resource Families and Residential Facilities in four broad categories



- Use Reasonable and Prudent Parent (RPP) standard to support the healthy sexual development of youth



- Assist the youth and/or NMD access health services
- Communicate with the caseworker if referrals must be made or they require assistance accessing resources and services



- Maintain the youth's privacy and confidentiality
- Direct youth to reliable sources of information



- Arrange for timely transportation to health-related services
- STRTPs must provide a locked storage container to all youth so they may store condoms, birth control, emergency contraception pills etc.

Source: CDSS ACL 16-88, California Plan to Address Unintended Pregnancy

(c) LA Reproductive Health Equity Project for Foster Youth

# Additional Resources:

- CDSS, “**Healthy Sexual Development Resource Guide for Children’s Residential Facilities and Resource Families** ” (2018), available on CDSS Healthy Sexual Development website
- CDSS **All-County Letter 16-88**, available on CDSS Healthy Sexual Development website
- Forthcoming **all-county letter on SB 89** with information on case plan documentation requirements and connecting youth to education that complies with California Healthy Youth Act

# Intersecting obligations of caregivers and workers to meet youth needs and honor their rights

Service need/right of youth	Caregiver obligation	Caseworker obligation
Transportation to appointment	Shall facilitate transportation	In collaboration with foster caregiver, ensure barriers to care are addressed.
Access to medically accurate, age appropriate, culturally sensitive sexual health information	In consult with caseworker, ensure youth in long term care receive information	Shall provide access to age appropriate medically accurate information about services and rights
Confidentiality and consent rights	Respect private storage space as it relates to reproductive health Respect confidential appointments	Shall inform youth of their consent and confidentiality rights Appropriately document
Appointments	Shall ensure youth receive annual health exams	Shall ensure youth are up to date on annual health exams
Neutral, nonbiased information and support for healthy sexual development	Shall not impose personal biases. Shall use reasonable and prudent parent standard to support normalcy	Shall not impose personal biases. Shall ensure barriers to care and information are addressed.

(c) LA Reproductive Health Equity Project for Foster Youth

Sources: CDSS ACL 16-88, Not all obligations are listed in this chart

# Case: Theresa

Theresa, a sixteen-year old foster youth, has shared with her foster parent that she is pregnant and wants to terminate her pregnancy. Theresa has scheduled an appointment for an abortion and asked her caregiver to drive her. The caregiver shares with Theresa's probation officer she is not comfortable with taking Theresa to an appointment for an abortion. Theresa's probation officer feels it is the caregiver's responsibility to transport Theresa to the appointment.

**What are the obligations of the caseworker and caregiver?**

*Source:* CDSS, A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention (2017)



# Important New Law: SB 89 (effective 7/2017)



**Case Plan Provisions:** Two new requirements to document that certain activities have been completed



**Training Provisions:** New training requirements for social workers, caregivers and judges.

# Caseplan Requirement 1: Comprehensive Sex Ed

For all youth 10 years of age or older and NMDs who are in middle or high school, **caseworker must review annually and update the plan as needed** to verify:

1. Youth or NMD has received or will receive comprehensive sexual health education compliant with California Healthy Youth Act from their public school:
  1. at least once in middle school and
  2. at least once in high school
2. If the youth/NMD did not receive the instruction in school, that case plan shall document how the county ensured or will ensure that they receive the education through an alternative source
3. Applies to youth 10 years of age or older and NMDs in middle and high school



# Comprehensive sexual health education in CA schools

## California Health Youth Act (CHYA), enacted 1/1/16

### 15 Training Criteria *(partial list below)*

- Age appropriate
- Medically accurate and objective
- Affirmatively recognize that people have different sexual orientations
- Teach pupils about gender, gender expression, gender identity
- Accessibility for disabled youth
- Culturally sensitive and appropriate for all ethnic backgrounds
- And more!

### 16 Required Topics *(partial list below)*

- Nature of HIV
- Effectiveness and safety of all FDA approved methods that prevent or reduce the risk of contracting HIV and other STIs
- Objective discussion of all legally available pregnancy outcomes
- Sexual harassment, sexual assault, sexual abuse, and human trafficking
- Adolescent relationship abuse and intimate partner violence
- And more!



# Caseplan Requirement 2. Informing and Access Documentation:

*For youth 10 years of age and older, caseworkers must document in the caseplan annually that they:*



Informed youth their **right to access** age-appropriate, medically accurate information about reproductive and sexual health care.



Informed youth of their **right to consent** to sexual and reproductive health services and right to confidentiality regarding those services.



Informed youth **how to access** reproductive and sexual health care services and **facilitated access** to that care, **including by assisting** with any identified barriers to care, as needed.

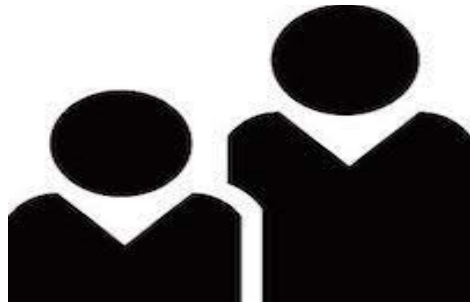
*These rights aren't new!*

*But requiring that completion of these activities be documented in the case plan annually is!*



# Training Provision: SB 89 has a Training Requirement

*Three groups are required to be trained:*



Caregiver



Social Worker



Judge

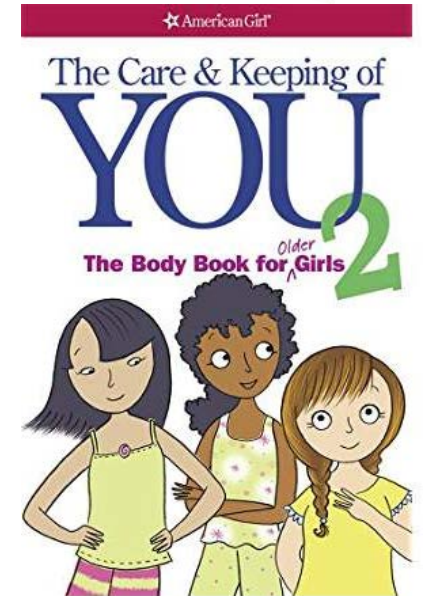
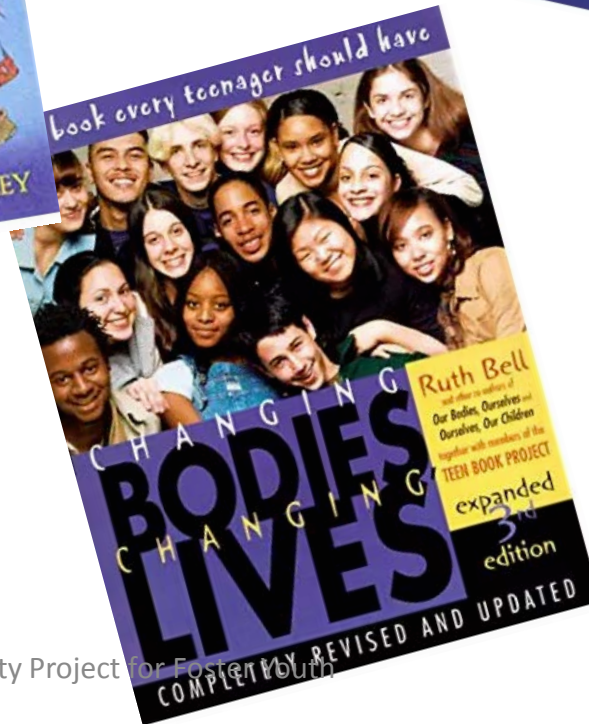
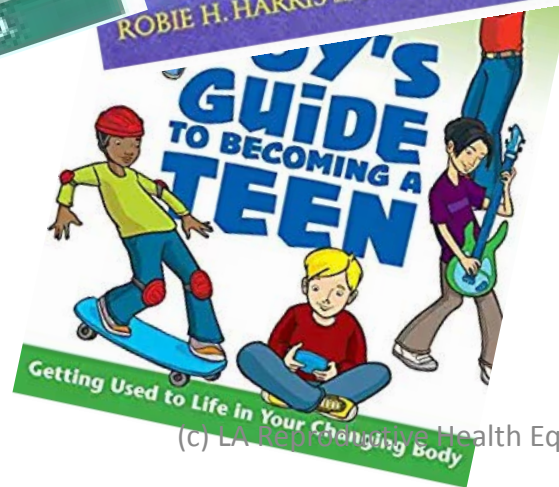
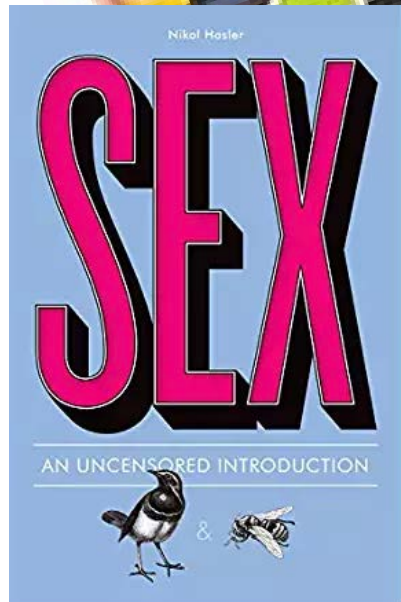
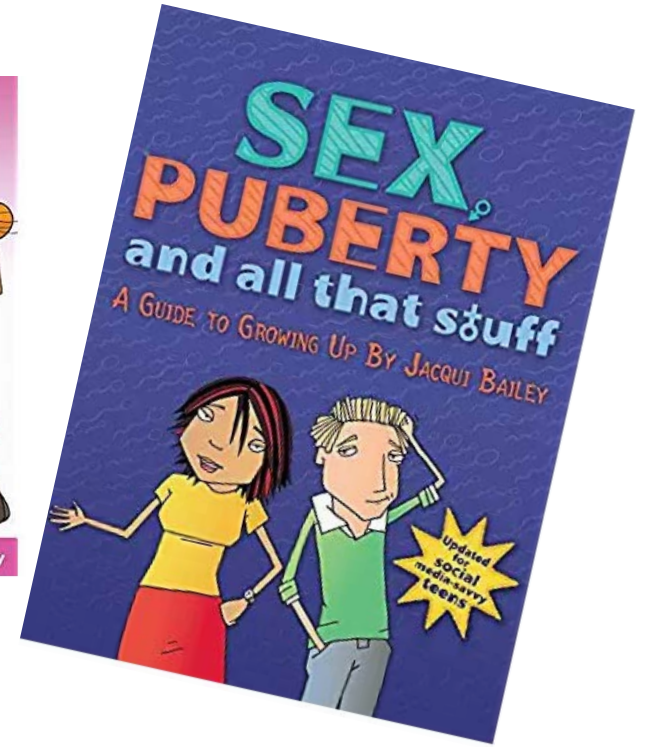
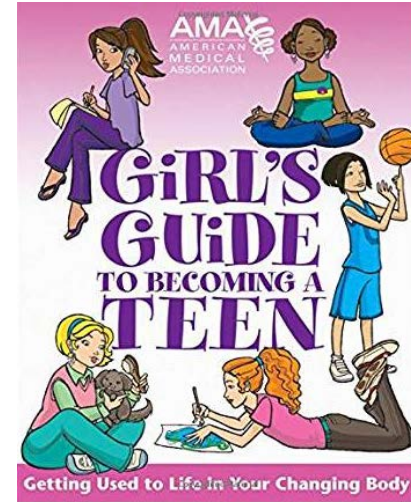
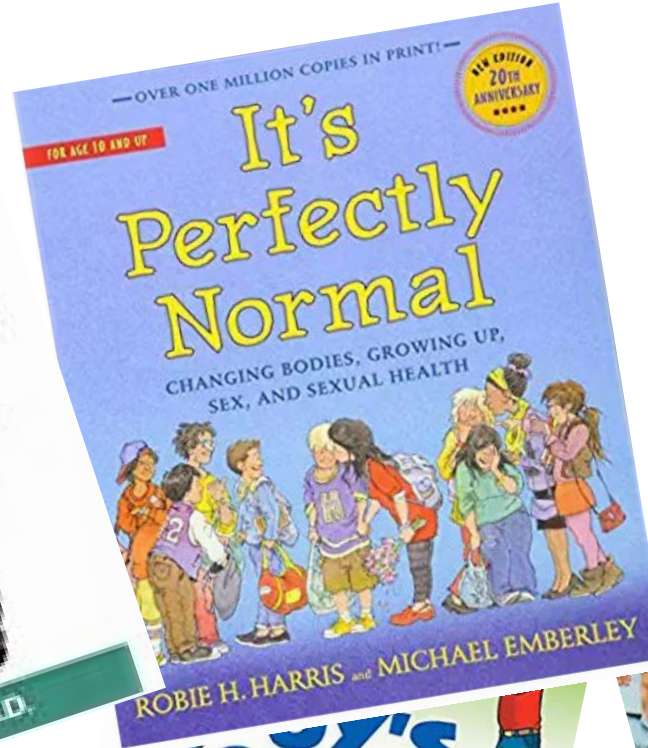
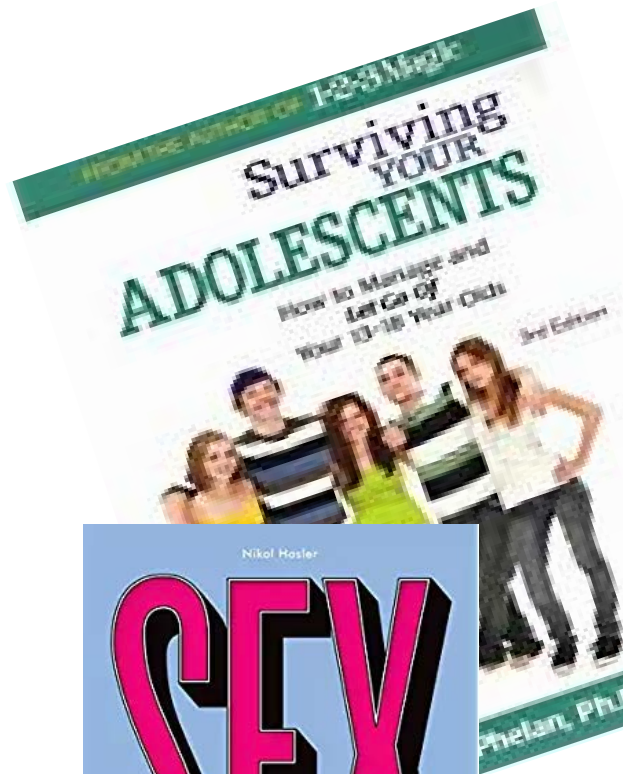
# Training is required to include:

- (1) The **rights** of youth and nonminor dependents in foster care to sexual and reproductive health care and information, to confidentiality of sensitive health information, and the reasonable and prudent parent standard.
- (2) How to **document** sensitive health information
- (3) The **duties and responsibilities** of the assigned case management worker and the foster care provider in ensuring youth and nonminor dependents in foster care can obtain sexual and reproductive health services and information.
- (4) Guidance about **how to engage and talk** with youth and nonminor dependents about healthy sexual development and reproductive and sex
- (5) Information about current **contraception methods**



# Communicating with Youth about Sexual Health

# We know this isn't easy!





**Start early**  
**Build Trust**  
**Suspend Judgment**  
**Offer Support**  
**Know Yourself and Your Own Relationship to the Topic**  
**Know the Facts**



# Tips for Effective Communication with Youth

- Do:
  - Stress positive attributes of teen, praise good work
  - Deliver clear messages
  - Listen and treat their comments seriously
  - Inform communication by reflecting on your own experiences as a teen
  - Keep sense of humor
  - Find moments for conversations
- Don't:
  - Compare with other teens
  - Lecture or moralize
  - Be judgmental or overly critical
  - Engage in power struggles

# Communicating with Youth from Youths' Perspective



- Be inclusive and not gendered in how you ask questions
  - For example, “are you in a relationship?” instead of “do you have a boyfriend?”
- Use broad open questions
- Watch physical cues for signs of anxiety or stress
- Don’t assume we are all sexually active and don’t assume we are not - we are not homogenous
- Some of us may already have experienced something nonconsensual
- Don’t set a lower bar for us just because we are in foster care
- Make sure there are no language barriers. Did youth really understand?

# Phrases youth would like to hear:



- “Is there any other way that I can help you?”
- “It’s totally fine, I understand”
- “If you have questions and I don’t know the answer, we can look them up together or figure out how to find the answer.”
- “If I say something wrong, please feel free to stop me and tell me.”
- “We understand not everyone is perfect.”

# Resources:

- [www.Talkwithyourkids.org](http://www.Talkwithyourkids.org)
- Handouts available online:
  - Parent-child communication
  - Know myself, know my child
  - Speaking to your child about difficult topics
  - All available in Spanish as well

## FOR PARENTS

### Parent-Child Communication

Many parents freeze when they are faced with talking to their children about sex. Many teens prefer to talk to their parents rather than doctors about sex. It can feel awkward, but you can help your child make healthy choices. They need you, and if you are not talking to them, somebody else will. Think about what you want them to know.

#### Why should you talk to your child about sex?

- ▶ Teens who feel connected to their home and families wait to have sex.<sup>1</sup>
- ▶ Teens whose parents talk to them about condoms are more likely to use them.<sup>2</sup>
- ▶ Teens who said they talked to their parents about sex are more likely to use contraception.<sup>1</sup>
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- ▶ Teens whose parent talk to them about their sexual orientation have lower risk for STIs, including HIV.<sup>4</sup>

#### It's not just what you say, but how you say it. Healthy communication means:

- ▶ Openness to all topics and ideas.
- ▶ Each party talks and also listens.
- ▶ Being warm and caring.
- ▶ Trying not to fight.

#### 4 Tips for Talking with You

- Even if your teen does not want to talk, let is an open door if and when they do.
- Many teens are afraid that they will disappoint you.



#### HABLE CON SU HIJO/A ADOLESCENTE SOBRE ASUNTOS DIFÍCILES

Los cambios naturales que ocurren durante los años de la adolescencia pueden resultar difíciles para usted y para su hijo/a. En muchas familias, puede haber desacuerdos cuando los hijos quieren más privacidad e independencia. Los padres pueden sentir que sus hijos/as son impulsivos e irrespetuosos.

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#### Consejos para hablar con su hijo/a adolescente:

<b>Hable:</b>	No tenga miedo de hablar sobre temas difíciles como el sexo y las drogas. Incluso si su hijo sólo tiene 10 u 11 años, usted puede hablar sobre la pubertad, presión social, y cómo mantenerse sanos. Esto le hará sentir más cómodo/a hablar con usted de estos temas.
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<b>Sea honesto:</b>	Dé respuestas honestas cuando su hijo/a adolescente le pida información. No se preocupe si no tiene todas las respuestas.
<b>Comparta sus ideas y opiniones:</b>	Los adolescentes quieren oír acerca de sus valores y creencias.
<b>Respete sus opiniones:</b>	Los adolescentes maduran y se independizan. Permitirles tomar sus propias decisiones es una parte importante de crecer. Pídale a su hijo/a que comparta con usted sus ideas y opiniones. Asegúrese de dejarle saber que usted siempre está ahí para ayudar, incluso si usted no está de acuerdo con todas sus decisiones o su comportamiento.
<b>Mantenga la calma:</b>	Trate de permanecer tranquilo/a si le comunica un problema preocupante, para que no tenga miedo de hablar con usted.
<b>Continúe hablando:</b>	Inicie conversaciones acerca de los temas una y otra vez. No tema iniciar conversaciones sobre temas importantes de los que ya ha hablado. Use películas, programas televisivos o noticias sobre la salud de los adolescentes como manera de comenzar conversaciones.



(NO TENGA MIEDO DE PEDIR AYUDA)

#### CONOCERME A MÍ MISMO/A ES CONOCER A MI HIJO/A ADOLESCENTE

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#### ¿Cómo me siento?

¿Está usted de buen humor? ¿Qué memorias afectan sus opiniones? Recuerde que lo que usted vivió de adolescente tal vez no sea lo mismo que lo que está viviendo su hijo/a adolescente ahora.

#### ¿Qué hacía yo a los 16 años?

¿Ha pensado usted en lo que quiere compartir con su adolescente? Espere hasta que su adolescente esté a la mitad de sus años de adolescencia antes de compartir información delicada con él o ella.

#### ¿Estamos encontrando algún tiempo juntos para disfrutar el uno de la compañía del otro?

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Pregúntele siempre a su adolescente lo que está haciendo en vez de pensar lo peor. Confíe en que él/ella puede tomar buenas decisiones.

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#### ¿Estoy dispuesto/a a recibir ayuda para cualquier problema que pudiera tener?

Es importante ser un ejemplo para su adolescente. Ver como recibe ayuda un miembro de la familia puede animar a su adolescente a recibir ayuda para sus propios problemas.

# **Confidentiality and Documenting Sexual and Reproductive Health Issues in a Case Plan**

*Source: CDSS, A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention (2017) at pages 4, 7.*

# CDSS Provides Guidance in Three Practice Areas



Informing youth about their confidentiality rights



Handling sexual and reproductive health information



Documenting sexual and reproductive health information

# Caseworkers are Required to Explain Two Confidentiality Rights to Foster Youth



At least once a year starting at age 10, caseworkers must inform the youth regarding:

1. their right to confidentiality in health care appointments and
2. their right to confidentiality with the case worker.



# Inform about Confidentiality with Caseworker

## Rights to Confidentiality with case worker:

**Before** receiving reproductive or sexual health information from a youth, case workers should explain to youth that the information they share **will remain confidential** unless:

- The youth consents to disclosure or
- there is a potential safety issue.

# How Sexual and Reproductive Health Information is Handled Depends on the Nature of the Activity



# Scenario 1: No Abuse or Exploitation is Alleged or Suspected



Jill is a fifteen year-old foster youth. She lets her case worker know she thinks she might be pregnant.

According to Jill, sex was consensual and the caseworker has no indications of abuse or exploitation.

*How should this be handled?*

This information is protected and it should not be disclosed, which includes documentation in a casefile or court report.

# Scenario 1: No Abuse or Exploitation is Alleged or Suspected



Case workers **should not disclose** any confidential information regarding a youth's reproductive health, such as:

- the youth's birth control method,
  - the youth being sexually active,
  - the youth's pregnancy, or
  - decision to terminate a pregnancy,
- without the written consent of the youth.



*“Disclose” includes any form communication, either written or verbal, formal or informal.*

# Scenario 1: No Abuse or Exploitation is Alleged or Suspected



What CAN be disclosed or documented:

- Caseworker and youth discussed topics of reproductive health
- Caseworker provided resources and information about reproductive health to the youth
- Caseworker offered to remove any barriers the youth may experience accessing reproductive health

*This disclosure describes the **action** the caseworker took to assist the youth, rather than **protected information** about the youth's actions.*

## Scenario 2: Abuse or Exploitation is Alleged or Suspected



Jill is a fifteen year-old foster youth. She lets her case worker know she thinks she might be pregnant.

Jill discloses to the caseworker that the person she had sex with was someone her boyfriend knew. She didn't really want to, but her boyfriend told her she would only have to do it this once and kept on her until she agreed.

*How should this be handled?*

## Scenario 2: Abuse or Exploitation is Alleged or Suspected



This along with other information known about Jill may lead the caseworker to believe he has a reasonable suspicion that Jill is a victim of trafficking and/or nonconsensual sex.

When caseworker must disclose pursuant to mandated reporting laws, the case worker should **inform the youth** that they will be disclosing the information, and explain the reasons for disclosing, prior to doing so.

The case worker may also consult with County Counsel.

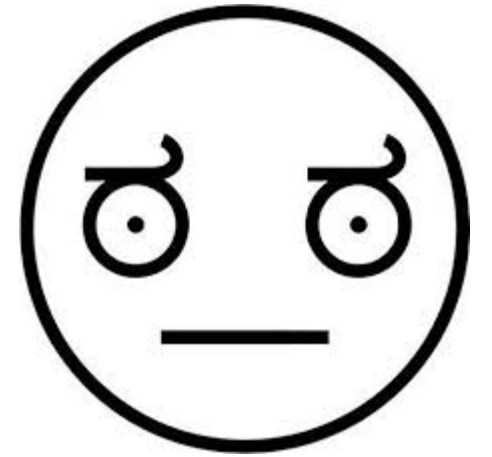
# Knowing the Difference Between Abuse/Exploitation and Normative Sexual Behavior is Essential





# We May Not Like or Approve of Specific Behavior, but It Does Not Automatically Constitute Abuse or Exploitation

- **Examples:**
- Multiple sexual partners
- Engaging in unprotected sex
- Treatment for multiple sexually transmitted infections
- Receipt of multiple abortions
- Sexually explicit texts
- Use of dating apps such as Tinder or Grindr (for NMDs)



# Documentation of Protected Information Requires Consent OR Alleged or Suspected Abuse or Neglect



- NO information should be documented that is legally protected
- As noted earlier, this includes confidential information regarding a youth's reproductive health, such as:
  - the youth's birth control method,
  - the youth being sexually active,
  - the youth's pregnancy, or
  - decision to terminate a pregnancy,**without the written consent of the youth.**

Documentation may include action the caseworker took to assist the youth rather than protected information about the youth's actions.

# If Consent is Provided, Information Must be Documented Carefully



Case managers should have conversations with foster youth about sharing or discussing their personal and confidential information with others to ensure that their information is safe and handled with care and respect.

- County agencies may benefit by creating a form for tracking who the youth consents to having this information and when consent was given.

# Required documentation: CDSS Has Provided Specific Guidance on Documenting Pregnancy



State and federal law require the collection of data on pregnancy and parenting status of foster youth. CDSS provides two ways to capture pregnancy information in CWS/CMS:

## Entering Pregnancy Information as an Observed Condition

- Ensures the information is not automatically populated on the Health and Education Passport
- Will keep the information private from those that receive copies of a youths' HEP

## Entering Pregnancy Information as a Diagnosed Condition

- Will result in the information being displayed in the HEP
- Necessary when the youth has been hospitalized as a result of the pregnancy such as a pregnancy complication or due to giving birth to a child

*See CDSS ACL 16-32*

# **Role of Attorneys and Judges**

Advocacy and Oversight Roles

# Keys to Healthy Decision-Making and Making Decisions Reality: Relationships, Knowledge, Motivation and Access

1. Supportive relationships between the youth and a caring **trusted adult**.
2. Comprehensive, **accurate information** from reliable sources about healthy relationships, safety, sex, reproductive health, pregnancy and contraception.
3. Motivation to make careful decisions is tied to the ability to envision a **bright future**.
4. Access to **tools and services** that allow them to realize their decisions

# What information regarding youth's knowledge, relationships, motivation and access will court and attorneys have?



1. Information from direct conversations with youth, caseworkers, caregivers, parents

15



2. Information in the case plan



3. Information in court reports- for counties that have chosen to add the information to court reports

# What sexual and reproductive health information will be in case plan?

Caseworkers are required to document annually for youth and NMDs 10 and older that the case worker has:

1. ***informed the youth*** in an age appropriate manner of their rights every six months
2. ***provided access*** to age appropriate, medically accurate information about sexual development, reproductive and sexual health care, prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and prevention and treatment of STIs.
3. ***facilitated access to sexual and reproductive health care***, including addressing any barriers to care, as needed
4. ***ensured provision*** of sexual health education at least once in middle and high school as required



# What type of information will be in the case plan?

Information about the **action** the caseworker took rather than *protected information* about the youth's actions or health conditions.

# Role of the Child's Attorney

# Role of Child's Attorney



Help them identify a **Trusted Adult**:

- Assume no one else is talking to them about sexual health
- It's never too early<sup>15</sup> to start a conversation about sex and relationships
- Have an open door for questions and conversation
- Who is their trusted adult? If they can't identify one, what steps can be taken to identify?



Ensure they have access to **Accurate Information**:

- Confirm they have received information from caseworker
- When will youth receive comprehensive sexual health education in school?
- Inform them of their rights
- Ensure they know about local resources and referrals
- Know where to look for answers- you don't have to be an expert
- Don't impose your values



# Role of Child's Attorney



## Motivation:

- Support planning for the future
- What supports and services are in place to maintain stability in the youth's placement, education, and extra curricular activities?
- Ask open questions and provide support
  - What do you want to be when you grow up?
  - How can we make your dream a reality?



## Advocate for Access and Address Barriers:

- Is youth aware of available services?
- Has youth faced barriers?
- Ask client and caseworker to inform you of any barriers to care or issues with placement



# **Role of Parent's Attorney**

# Role of the Parent's Attorney

- Discuss with the parents, as appropriate, that their child must be informed of their sexual and reproductive health care rights and access to services in an age and developmentally appropriate way.
- Reassure them that all adolescents have these rights and it's not just about their child.
- Provide information on how to be a trusted and supportive parent to a teen.
- Advise client to talk to the Social Worker or Probation Officer with any concerns.
- Review the case plan with your client and discuss any issues in this area that cause your client concern.

# Resources:

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# **Role of the Court and Judicial Officers**



# Role of the Court

- Ensure that the appropriate person focuses on the youth's sexual and reproductive health
- Ensure that the youth receives the **support and knowledge** needed to make healthy long-term decisions regarding sex and pregnancy planning and has the **tools and access** to make those decisions a reality

# Role of the Court

The court must find that the agency has **complied** with the case plan requirements, specifically, in this context:

1. That the caseworker has verified annually that the youth or NMD received or will receive comprehensive sexual health education that meets the requirements of CHYA
  - At least once in junior or middle school, AND
  - At least once in high school

Compliance: What does verified mean? When is sexual health education offered in the school districts? Was the youth attending school at that time? Did the youth change schools?

# Role of the Court

The court must also find that the agency has **complied** with the case plan requirements, specifically, in this context:

2. That for youth 10 years of age and older or NMDs, the caseworker **informed** the youth of their right to:
  - *access* age appropriate, medically accurate information about sexual development, reproductive and sexual health care, prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and prevention and treatment of STIs.
  - *Consent* to sexual and reproductive health services and his/her *confidentiality* rights regarding those services.

Compliance: What does it mean to inform?

# Role of the Court

The court must also find that the agency has **complied** with the case plan requirements, specifically, in this context:

3. That for youth 10 years of age and older or NMDs, the caseworker **informed** the youth how to access reproductive and sexual health care services AND **facilitated** access to care, including addressing any barriers to care, as needed.

Compliance: What does facilitated mean?

# Special Challenges For Court when Engaging with Foster Youth

- Limited time to engage with youth
- Not a trained expert in this area
- Lack of clear protocols or guidance
- Varied ethnic, cultural and religious backgrounds
- Concern with overstepping/privacy

# Strengths and Opportunities of Judges

- Consistent, long term presence, continuity
- Can enlist support from other court-affiliated professionals and staff to address sexual health issues
- Use immediate presence with youth to help understand changes in their lives related to sexuality and sexual expression

# Questions Judges Can Ask Youth to Ensure Youth Makes Knowledgeable Decisions and Has Ability to Effectuate Those Decisions

- **Trusted adult:**

- Do you have someone you can speak with?

- **Knowledge:**

- Are you aware of your rights to services and information?
- Have you been connected to resources?

- **Motivation:**

- What do you want to be when you grow up?
- How can we make your dream a reality?
- Do you want to have a family someday?

- **Access:**

- Are your health needs being met?

# Communicating with Judges from Youths' Perspective



“Judges can be scary”

“We are not always acknowledged in the courtroom”

“Look at us in the eye when speaking to and about us”

“Ask us open ended questions to learn our level of comfort”

“Have a conversation about our rights, benefits and resources- no specifics”

For example: “Have you received the information you need?”

“If there is specific concern, speak to our attorney, CASA etc. before the hearing and ask them to have the conversation with us in private”



# Case: Sunny

Sunny, a fourteen year old girl, walks into court and she is visibly pregnant. There is no mention of the pregnancy in the court report. The judge does not have any additional information about the pregnancy, the circumstances, motivation, etc.

- Should the judge address the pregnancy with the youth in open court?
- If so, how should the judge raise the issue?
- If not, what if anything should the judge do?

# Case: Jamie

Jamie is a sixteen year old who is 30 weeks pregnant. Prior to the pregnancy, Jamie was taking a psychotropic medication for diagnosed bipolar disorder. She stopped taking the medication upon learning of her pregnancy, on her doctor's recommendation.

The agency just submitted a request to the court for an order that would authorize any necessary delivery care, including surgery or medication, upon physician recommendation.

- Is such an order necessary?
- How should the court handle this request?

# Test Yourself: Which is myth and which is fact?

1. Caseworkers must provide foster youth with age appropriate information on sexual and reproductive health annually, starting at age 10. **Fact**
2. Youth under age 12 have a right to obtain and use contraception confidentially. **Fact**
3. Youth 12 and older have a right to obtain and use condoms confidentially. **Fact**
4. It is illegal for a CASA to speak to a foster youth regarding STI's and safe sex without first obtaining parent or caseworker permission. **Myth**
5. Foster parents have a duty to inform child welfare if a youth requests transportation to an abortion appointment. **Myth**

# **Bringing it all together: Case Examples**

# Case: Molly

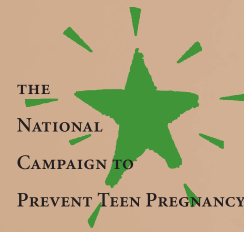
Molly is 15 and in Alpha STRTP. Alpha keeps Molly's birth control pills and she has to ask to take them. Because of this, Molly is not consistent in taking her pills. Molly ran away from the STRTP for a few days a month ago to meet up with her boyfriend. She recently found out she was pregnant and wants to keep the baby. She has told her worker and her bio mom, who is supportive, but does not feel comfortable with telling group home staff.

- What should the social worker/probation officer do?
- What is the role of Molly's attorney?
- What is the role of Mom's attorney?
- What is the role of the court?

# Case: Evan

Evan is 13 years old. He has been in placement since the age of 11 and has moved schools 3 times. He is currently living in a Christian based foster home. He likes his foster parents, but they have only told him that sex is saved for marriage. Evan is currently exploring his sexual identity and has a lot of questions.

- What is the role of Evan's attorney?
- What should the worker be doing?
- What information does the court need to make its findings?



# 10 TIPS for Foster Parents

To Help Their Foster Youth Avoid Teen Pregnancy



[WWW.TEENPREGNANCY.ORG](http://WWW.TEENPREGNANCY.ORG)



**The good news for parents and other caring adults, including foster parents, is that there is much they can do to help influence their children's decisions about sex.**

Foster youth say they want to discuss sex, love, and relationships with their foster parents, but some are embarrassed or feel uncomfortable starting the conversation. The same holds true for foster parents. They often don't know what to say, how to say it, or when to start. This guide offers some ideas to help foster parents strengthen their relationships with foster youth. It also offers some ideas on how best to communicate about sex, love, and relationships.

Youth in foster care are at greater risk for early pregnancy than teens in general. One study finds that almost one-third of girls in foster care become pregnant at least once by age 17—almost one-half by age 19.<sup>1</sup> Preventing early pregnancy and parenting is important for a number of reasons. Compared to women who delay childbearing, teen mothers are more likely to drop out of school and to live in poverty. Their children are more likely to experience abuse and neglect, enter the child welfare system, be born at low birth weight or mentally retarded, grow up poor, perform poorly in school, and have insufficient health care. Daughters of teen mothers are more likely to become teen parents. Sons of teen mothers are more likely to be incarcerated.

This brochure provides tips on such topics as the importance of maintaining strong, close relationships with children and teens, setting clear expectations for them, and communicating honestly and often with them. Research supports these common sense lessons: not only are they good ideas generally to promote positive youth development, but they can also help teens delay becoming sexually active, as well as encourage those who are having sex to make more responsible choices and use contraception carefully. ■

1 Blaver, L., Courtney, M. (2006). Foster Care Youth, 28. Washington, DC: National Campaign to Prevent Teen Pregnancy.

## TIP # 1

**Build a relationship based on trust and compassion.**

**S**ome foster youth have had few positive relationships with adults. Many have been moved from home to home, others have experienced abuse and neglect. Let them know early and often that they are welcome in your home, it is safe, and that you care about them. Show them they are important and valued. In other words, do all you can to build a warm, trusting relationship right from the start. Your foster child will feel more comfortable talking to you about a personal topic such as sex, if they feel they can trust you. Understand, too, that a close relationship between caring adults and teens helps young people avoid multiple risky behavior, including early pregnancy and parenthood.

Of special concern: Building strong relationships and talking about sex can be more complex if your foster youth has been sexually abused. They may blame themselves for the abuse. They may have confused feelings about the meaning and purpose of sex. Foster parents, along with a team of case workers and mental health professionals, must work together with the youth to effectively manage anger, teach what is appropriate sexual behavior, and rebuild self esteem and trusting relationships with adults. ■

**“Before you have the sex talk, get to know your foster kids better. Don't start talking about it as soon as they enter your house. We (foster youth) build trust with foster parents little by little until we get to the point to where we truly do trust them.” ~ Advice from a foster teen to foster parents**



# TIP # 2

## Talk with your foster children often about sex, and be specific.

Ideally, age-appropriate conversations about relationships and intimacy should begin early in a child's life and continue through adolescence. Even if your foster child enters your house as an older teen, it's never too late to talk to them about sex. All kids need a lot of communication, guidance, and information about these issues, even if they sometimes don't appear to be interested in what you have to say. Resist "the talk" — make it an ongoing conversation. Remember to talk to both your foster daughters and foster sons. Remember too that both foster mothers and foster fathers should be involved in these conversations.

When you start the conversation, make sure that it is honest, open, non-judgmental, and respectful.

Be sure to have a two-way conversation, not a one-way lecture. Ask your teens what *they* think and what they know so you can correct misunderstandings or myths. Ask what worries them. Be a good listener and let your teens talk. Tell them truthfully and confidently what you think and why you think this way. If you're not sure about some issues, tell them that, too.

By the way, research clearly shows that talking with your children about sex does not encourage them to become sexually

"It can't be a one-time conversation, like 'Yeah, I can check that off the list—I had the sex education conversation.' It needs to be an ongoing conversation." ~ Foster father

active. Also keep in mind that your own behavior should match your words. Teens are careful watchers of adults and are very sensitive to hypocrisy.

Don't feel as though you have to "know it all." Teens need help in understanding the meaning of sex, not just how all the body parts work. Tell them about love and sex, and what the difference is. Talk to them about the future and commitment. And remember to talk about the reasons that kids find sex interesting and enticing; discussing only the "downside" of unplanned pregnancy and disease misses many of the issues on teenagers' minds. You will be a better communicator if you are sensitive to your foster youth's culture and religion, as well as their sexual orientation.

Some foster youth have a strong desire to have a child right away. They may seek to create their own family as a source of stable relationships and unconditional love. Have a frank and detailed discussion with your foster teens about how they plan to support a baby through 18 years of life and provide the emotional and financial opportunities they want for their children. Oftentimes, youth do not fully understand the true costs of raising a child. You can help give them a reality check.

Keep your case worker informed about your discussions with your foster youth. He or she can reinforce your messages with the foster youth and support you with any concerns you may have.

### Be an askable foster parent. Here are some of the kinds of questions that your foster children may want to discuss:

- How do I know if I'm in love? Will sex bring me closer to my girlfriend/boyfriend?
- How will I know when I'm ready to have sex?
- Will having sex make me popular? How will sex affect my relationships now and in the future?

- How do I tell my boyfriend that I don't want to have sex without losing him or hurting his feelings?
- How do I manage pressure from my girlfriend to have sex?
- How do I deal with pressure from my friends to have sex?
- How does contraception work? Are some methods better than others? Are they safe?
- Can you get pregnant the first time?
- Why should I wait to have a baby?

**Be a parent with a point of view. Don't be shy about saying:**

- I think sex should be associated with commitment and teens simply aren't ready to commit.
- When you eventually do have sex, always use protection until you are ready to have a child.
- Have a plan. Think in advance about how you'll handle the heat of the moment. Will you say "no"? Will you use contraception? What if your partner wants to have sex but doesn't want to use contraception?
- It's okay to think about sex and feel sexual desire; everybody does. But it doesn't mean you have to act on these feelings now.
- One of the many reasons I'm concerned about drinking and drug use is that they are often linked to bad decisions about sex.
- Having a baby doesn't make you a man. Being strong enough to wait and act responsibly does.
- You don't have to have sex to keep a boyfriend. If sex is the price of a close relationship, then think again about the relationship. ■

## TIP # 3

### Spend quality time with your foster child.

**T**eens who are close to their parents/foster parents and feel supported by them are more likely to wait until they are older to begin having sex, have fewer sexual partners, and use contraception more consistently. Simply having a caring parent around can make a real difference.

Family activities such as going out to the movies or outdoor activities can be quite important in a foster child's life. Try to eat and/or cook dinner together as often as possible and use the time for conversation, not confrontation. Something as simple as a car ride can be a perfect time to have meaningful conversations and learn about each other. Be supportive and be interested in what interests them. Attend their sports events; learn about their hobbies; be enthusiastic about their achievements, even the little ones; ask them questions that show you care and want to know what is going on in their lives. ■

**"Quality time is the time that child will allow you to have, so make the most of it. It could be an hour or just 10 minutes. Get them to open up and talk to you – build a relationship and friendship with them." ~ Foster mother**

# TIP # 4

## Supervise and monitor your foster children and adolescents.

**D**o your best to establish rules, curfews, and standards of expected behavior, preferably through open family discussions. This may be difficult since some foster children may try to test your parental limits. Foster youth may contact their birth parents in hopes they will disagree with your rules. However, most foster teens respect guidelines and structure — it shows that you care about them.

If your foster child gets out of school at 3 pm and you don't get home from work until 6 pm, who is responsible for making certain that your foster child is not only safe during those hours, but also involved in positive activities? Where are they when they go out with friends? Are there adults around who are in charge? Supervising and monitoring your foster child's whereabouts doesn't make you a nag; it makes you a caring foster parent. ■

# TIP # 5

## Know your foster children's friends and their families.

**C**learly, friends have a strong influence on each other — both positive and negative. Foster parents should know that there is much they can do to help build on positive peer influence, and help foster teens steer clear of risky friendships. Whenever possible, meet the parents of your foster child's friends so that you can get to know them and try to establish common rules and expectations. It is easier to enforce a curfew that all your foster child's friends share rather than one that makes him or her different — but even if your views don't match those of other parents, hold fast to your convictions. Welcome your foster child's friends into your home and talk to them openly.

Keep in mind that if your foster child has moved around often, she/he may have to make a whole new set of friends. Some foster teens do not want anyone to know they are in foster care and may be reluctant for their foster parents to meet their friends. Don't be discouraged. ■

*“I often invite the parents of my foster children's friends over for dinner to get to know the family.” ~ Foster mother*

*“I drop my foster daughter off at friends' houses and go in and meet the parents.” ~ Foster mother*

*“My house is the 'hang out.' I have plenty of food around and games for them to play. At times it's inconvenient, but it works. I know that my foster children are safe and it's an opportunity to get to know their friends too.” ~ Foster mother*

# TIP # 6

**Know what your foster kids are watching, reading, and listening to.**

**T**oday's teenagers spend over 40 hours *each week* consuming media. Television, music, movies, videos, magazines, and the Internet send many messages about sex: Sex often has no meaning or consequences, unplanned pregnancy seldom happens, and few people in the media having sex ever seem to be married or even especially committed to each other. Is this consistent with your expectations and values? If not, it is important to talk with your foster children about what the media portray and what you think about it.

Encourage your kids to think critically: ask them what they think about the programs or movies they watch and the music they listen to. Watch their favorite shows with them and ask whether what they see on TV relates to anything in their lives or their friend's lives. While you cannot fully control what your foster children see and hear, you can certainly make your views known and control the media in your own house. For example, you can put the computer and television in an open space, not in a bedroom, so that they are easier to monitor. ■

"I watch BET; I sit there with them. We watch the rap videos and we talk about movies, religion, their friends—everything. You have got to be able to communicate with them at all costs." ~ Foster father

# TIP # 7

**Don't forget the boys — Talk to your foster sons and your foster daughters. Avoid the double standard.**

**T**he 820,000 teen girls who get pregnant each year don't do it alone. Boys may feel a lot of pressure to have sex to prove something to their friends or to impress a girl. Talk with boys — not just girls — about the emotional and health consequences of sex, responsibility, love, and values. Boys need to know that teen pregnancy has serious consequences for them, too. Some people have said that "a few minutes of pleasure can lead to 18 years of responsibility." Tell them how becoming a parent carries financial consequences and can interfere with achieving their educational and career goals. ■

# TIP # 8

**Discourage dating at an early age.  
Watch out for age differences in relationships.**

Allowing your foster teens to enter a serious dating relationship much before age 16 can lead to increased risk for getting pregnant. Instead, support group activities. Make your strong feelings about this known early on — that way it won't appear as though you disapprove of a particular person.

In addition, take a strong stand against your foster daughter dating a boy significantly older than she is. Don't allow your foster son to develop an intense relationship with a girl much younger than he is.

Try setting a limit of no more than a two- (or at most three) year age difference. Older guys often seem more mature or even glamorous to a younger girl. The power differences between younger girls and older boys, however, can lead girls into risky situations, including unwanted sex and sex with no protection. Young boys with older girls bring similar risks. ■

“I have a no dating rule for my younger teens. But once they start driving, it's difficult to forbid dating. I talk to my older foster teens about what they want in a relationship and about their definition of dating. I have them bring their boyfriend or girlfriend over to the house so I can meet them. I try to meet the parents too.” ~ Foster mother

“Older men take advantage of you because they think you don't know any better.” – Foster teen

# TIP # 9

**Encourage your foster child to become involved in positive activities such as sports, arts, community-service, faith-based activities, or other after-school programs.**

Getting involved in hobbies, sports, or the arts can help foster youth build confidence and self-esteem by mastering skills. Self-esteem is earned, not given. One of the best ways to earn it is by doing something well. Give them something positive to say “yes” to by providing them with alternatives to engaging in risky behavior. Community service, in particular, not only teaches job skills, but can also put teens in touch with other committed and caring adults. Many religious organizations have positive youth activities. Check out the resources for foster youth in your community such as camps, mentoring programs, and college preparation courses. ■

“My foster parent had me involved in extra-curricular activities. Tap dancing, math classes, after-school programs, etc. And that was good, it took my mind off of the negative things in my life. I didn't have so much free time on my hands to actually think about sex.” ~ Foster teen

# TIP # 10

**Help your foster teens to have options for the future that are more attractive than early pregnancy and parenthood.**

The chances that your foster children will delay sex, pregnancy, and parenthood are significantly increased if they believe they have a successful future ahead of them. This means highlighting their talents, helping them set meaningful goals for the future, talking to them in concrete terms about what it will take to reach their goals, and providing help along the way. Encourage them to take school seriously and graduate high school. Take them to visit college campuses. Teach them to use free time in a constructive way, such as setting aside time to complete homework assignments. Explain how becoming pregnant or causing a pregnancy can get in the way of their plans for the future. Let them know that they will be able to provide their children with a better life than they had growing up if they wait until they finish school, have a good job, and are in a stable, caring relationship. Some foster youth may feel it is impossible to achieve all these things. Regardless, it is still important to encourage them to have aspirations and help them make those aspirations a reality. ■

“If you have already made plans or have goals of what you plan to do with your life, then having a baby is definitely going to delay that.” ~ Foster teen

**A final note.** Becoming a foster parent can be one of life’s most rewarding and challenging responsibilities. Helping any youth navigate the passage to adulthood, in general, and avoid such problems as pregnancy, violence, drugs, alcohol, smoking, and school failure can be daunting. Remember that you can make a difference. In particular, a close relationship with your foster children can be the best protection of all. It’s never too early or too late to strengthen a relationship with a teenager or to educate them about sex, love, and relationships.

**Need more information?** The National Campaign to Prevent Teen Pregnancy offers many resources for parents in general on teen pregnancy. These materials include brochures and videos; all of them are low cost and many of them are free to download. Please visit the parent section of our website at [www.teenpregnancy.org](http://www.teenpregnancy.org).

The National Foster Parent Association is a national organization which strives to support foster parents and remains a consistently strong voice on behalf of all children. Their website has links to state foster parent associations. Please visit [www.nfpainc.org/](http://www.nfpainc.org/).

FosterClub is a national organization with a mission to provide encouragement, motivation, information, education, and benefits for foster youth. Their website features stories from successful former foster youth, contests, and opportunities for youth to send in opinions about their foster care experience, and more. Please visit [www.fosterclub.com](http://www.fosterclub.com) and [www.fyi3.com](http://www.fyi3.com).

The National Campaign to Prevent Teen Pregnancy would like to thank the Fairfax County Department of Family Services, DC Metropolitan Foster and Adoptive Parents Association, and UCAN (Uhlich Children’s Advantage Network of Chicago) for organizing focus groups with foster parents. We also extend warm appreciation to those individuals who participated in the focus groups—their helpful comments are reflected throughout this publication. We also thank the many reviewers whose suggestions have improved this document. Finally, special thanks to UCAN, who has been a main partner throughout this initiative.

# Ten Tips for Parents

To Help Their Children Avoid Teen Pregnancy



The National Campaign  
to Prevent Teen and Unplanned Pregnancy





# Ten Tips for Parents

## To Help Their Children Avoid Teen Pregnancy

The National Campaign to Prevent Teen Pregnancy has reviewed research about parental influences on children's sexual behavior and talked to many experts in the field, as well as to teens and parents themselves. From these sources, it is clear that there is much parents and adults can do to reduce the risk of teen pregnancy.

Many of these ideas presented here will seem familiar because they articulate what parents already know from experience — like the importance of maintaining strong, close relationships with children and teens, setting clear expectations for them, and communicating honestly and often with them about important matters. Research supports these common sense ideas. We hope that these tips can increase the ability of parents to help their children pass safely into adulthood pregnancy-free.

## So, what to do?

## **1. Be clear about your own sexual values and attitudes.**

Communicating with your children about sex, love, and relationships is often more successful when you are clear in your own mind about these issues. To help clarify your own attitudes and values, think about the following kinds of questions.

- » **What do you really think about school-aged teenagers being sexually active — perhaps even becoming parents?**
- » **Who is responsible for setting limits in a relationship and how is that done, realistically?**
- » **Were you sexually active as a teenager and how do you feel about that now? Were you sexually active before you were married? What do such reflections lead you to say to your own children about these issues?**
- » **Is abstinence best for teens? What do think about teens using contraception?**





**2. Talk with your children early and often about sex, and be specific.** Young people have lots of questions about sex, love, and relationships. And they often say that the source they'd most like to go for answers is their parents. Start the conversation, and make sure that it is honest, open, and respectful. If you can't think of how to start the discussion consider using situations shown on TV or in the movies as conversation starters. Tell teens candidly and confidently what you think and *why* you believe what you do. If you're not sure about some issues, tell them about that, too. Be sure to have a two-way conversation, not a one-way lecture. Ask them what *they* think and what they know so you can correct misconceptions. Ask what, if anything, worries them.

Age-appropriate conversations about relationships and intimacy should begin early in a child's life and continue through adolescence. Resist the idea that there should be just one conversation about all this — you know, “the talk.” Think 18 year conversation. The truth is that parents and kids should be talking about sex and love all along. This applies to *both* sons and daughters and mothers and fathers. All teens need large amounts of communication, guidance, and information about these issues, even if they sometimes don't appear to be interested in what you have to say. And if you have regular conversations, you won't worry so much about making a mistake, because you'll always be able to talk again.

Many inexpensive books and videos are available to help with any detailed information you might need, but don't let your lack of technical information make you shy. Kids need as much help in understanding the *meaning* of sex as they do in understanding how all the body parts work. Tell them about love and sex, and what the difference is. And remember to talk about the reasons that kids find sex interesting and enticing; discussing only the "downside" of unplanned pregnancy and disease misses many of the issues on teenagers' minds.

**Be an "askable parent."** Here are the kinds of questions kids say they want to discuss:

- » **How do I know if I'm in love? Will sex bring me closer to my girlfriend/boyfriend?**
- » **How will I know when I'm ready to have sex? Should I wait until marriage?**
- » **Will having sex make me popular? Will it make me more grown-up and open up more adult activities to me?**
- » **How do I tell my boyfriend that I don't want to have sex without losing him or hurting his feelings?**
- » **How do I manage pressure from my girlfriend to have sex?**
- » **How does contraception work? Are some methods better than others? Are they safe?**
- » **Can you get pregnant the first time?**

**And, be a parent with a point of view.** Tell your children what you think. Don't be reluctant to say, for example:

- » **I think kids in high school are too young to have sex, especially given today's risks.**
- » **Whenever you do have sex, always use protection against pregnancy and sexually transmitted diseases until you are ready to have a child.**
- » **Our family's religious tradition says that sex should be an expression of love within marriage.**
- » **Finding yourself in a sexually charged situation is not unusual; you need to think about how you'll handle it in advance. Have a plan. Will you say no? Will you use contraception? How will you negotiate all this?**
- » **It's okay to think about sex and to feel sexual desire— everybody does. But it's not okay to get pregnant/get somebody pregnant as a teenager.**
- » **(For boys) Having a baby doesn't make you a man. Being able to wait and acting responsibly does.**
- » **(For girls) You don't have to have sex to keep a boyfriend. If sex is the price of the relationship, find someone else.**

By the way, research clearly shows that talking with your children about sex does not encourage them to become sexually active. And remember that your own behavior should match your words.





### **3. Supervise and monitor your children and adolescents.**

Establish rules, curfews, and standards of expected behavior, preferably through an open process of family discussion and respectful communication. If your children get out of school at 3 pm and you don't get home from work until 6 pm, who is responsible for making certain that your children are not only safe, but also are engaged in useful activities? Where are they when they go out with friends? Are there adults around who are in charge? Supervising and monitoring your kids' whereabouts doesn't make you a nag; it makes you a parent.

### **4. Know your children's friends and their families.**

Friends have a strong influence on each other, so help your children and teenagers become friends with kids whose families share your values. Some parents of teens even arrange to meet with the parents of their children's friends to establish common rules and expectations. It is easier to enforce a curfew that all your child's friends share rather than one that makes him or her different — but even if your views don't match those of other parents, hold fast to your convictions. Welcome your children's friends into your home and talk to them warmly and openly.

**Teens say *parents* most influence their**

**decisions about sex.**

**5. Discourage early, frequent, and steady dating.**

Group activities among young people are fine and often fun, but allowing teens to begin one-on-one dating much before age 16 can lead to trouble. Let your child know about your strong preference about this throughout childhood — don't wait until your young teen proposes a plan that differs from your preferences in this area; otherwise, he or she will think you just don't like the particular person or invitation.

**6. Take a strong stand against your daughter dating a boy significantly older than she is. And don't allow your son to develop an intense relationship with a girl much younger than he is.**

Older guys can seem glamorous to a young girl. But the risk of matters getting out of hand increases when the guy is much older than the girl. Try setting a limit of no more than a two (or at most three) year age difference. The power differences between older boys or men and younger girls can lead girls into risky situations, including unwanted sex and sex with no protection.





**7. Help your teenagers to have options for the future that are more attractive than early pregnancy and parenthood.**

The chances that your son or daughter will delay having sex, pregnancy, and parenthood are significantly increased if their future appears bright. This means helping them set meaningful goals for the future, talking to them about what it takes to make future plans come true, and helping them reach their goals. Tell them, for example, that if they want to be a teacher, they will need to stay in school in order to earn various degrees and pass certain exams. It also means teaching them to use free time in a constructive way, such as setting aside certain times to complete homework assignments. Explain how becoming pregnant — or causing pregnancy — can derail the best of plans; for example, child care expenses might make it almost impossible to afford college. Community service, in particular, can not only teach job skills, but can also put teens in touch with a wide variety of committed and caring adults.

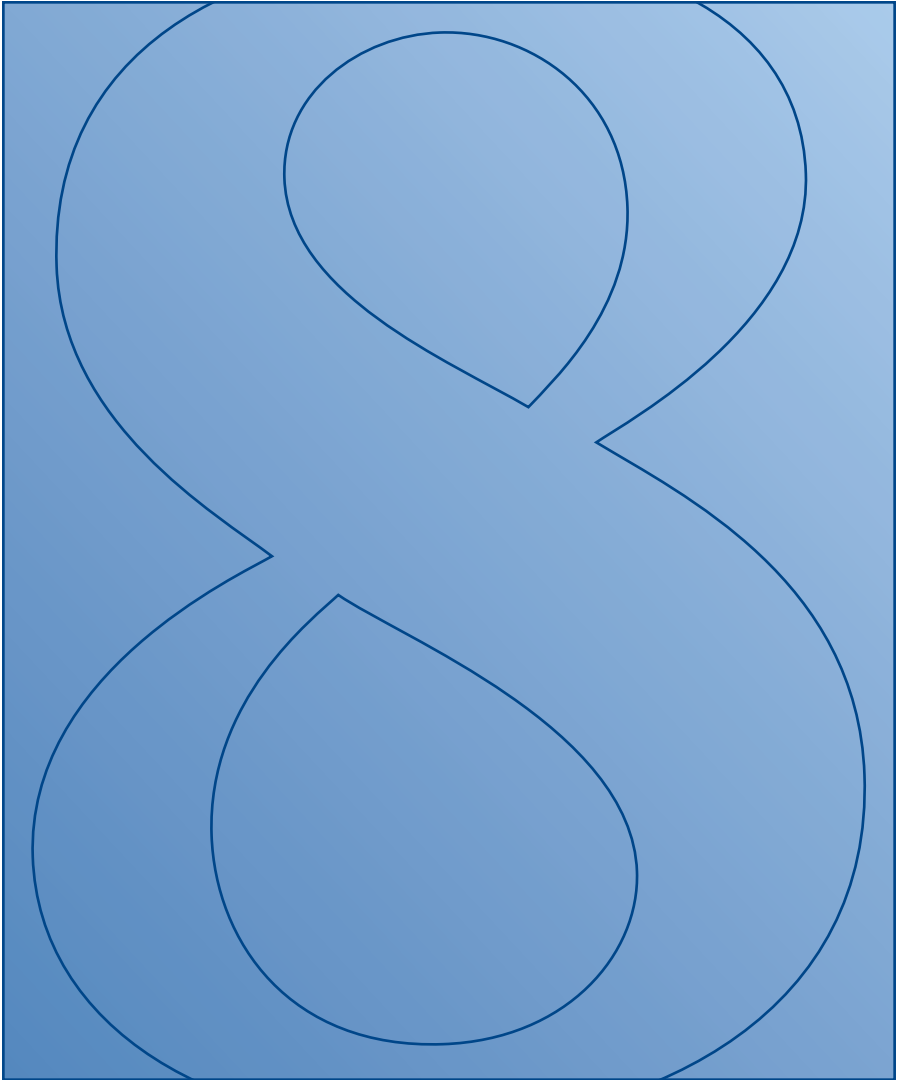
**Seven in ten teens agree  
it would be much easier for  
them to postpone sexual activity  
and avoid teen pregnancy if they  
were able to have more open,  
honest conversations about  
these topics with their parents.**

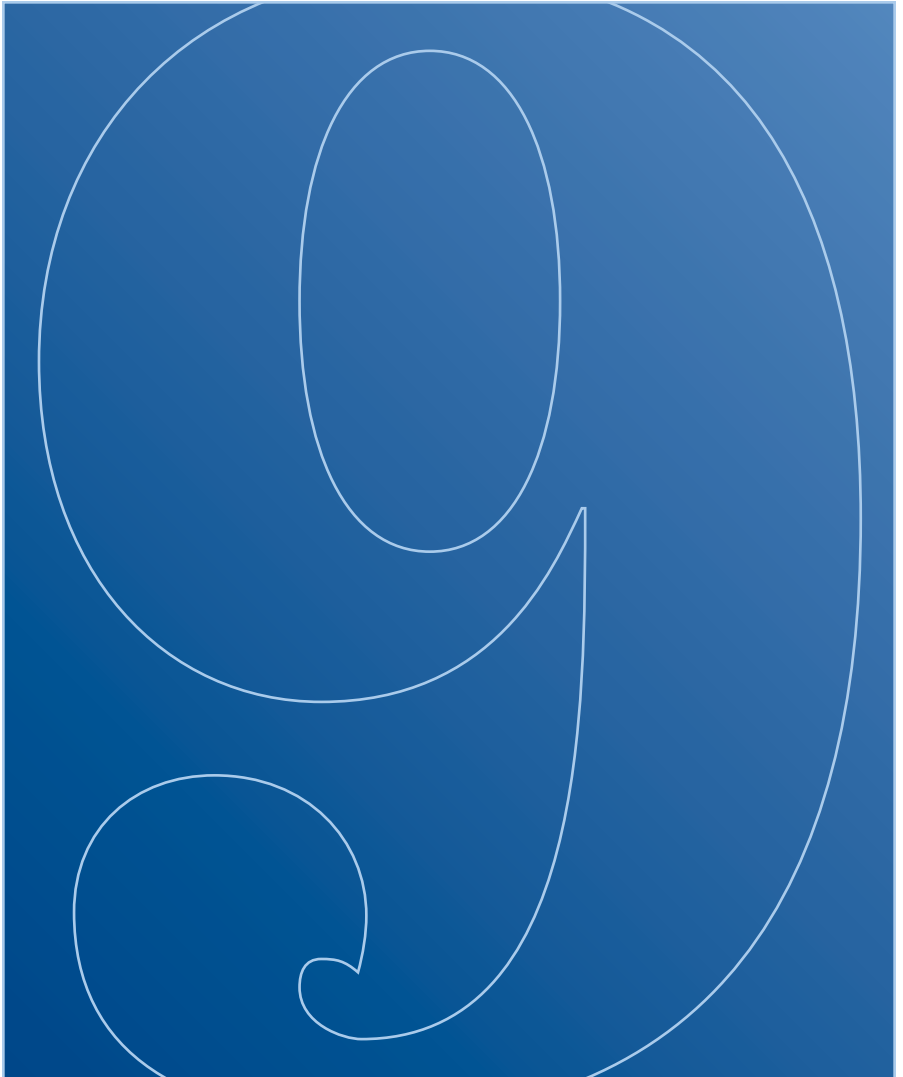


**Six in ten teens say that when it comes to talking about sex, parents send one message to their sons and a different message to their daughters.**

**8. Let your kids know that you value education highly.**

Encourage your child to take school seriously and set high expectations about their school performance. School failure is often an early sign of trouble. Be very attentive to your child's progress in school and intervene early if things aren't going well. Keep track of your children's grades in school and discuss them together. Meet with teachers and principals, guidance counselors, and coaches. Limit the number of hours your teenagers give to part-time jobs (20 hours a week should be the maximum) so that there is enough time and energy left to focus on school. Know about homework assignments and support your child in getting them done. Volunteer at the school, if possible. Schools want more parental involvement and will often try to accommodate your work schedule, if asked.



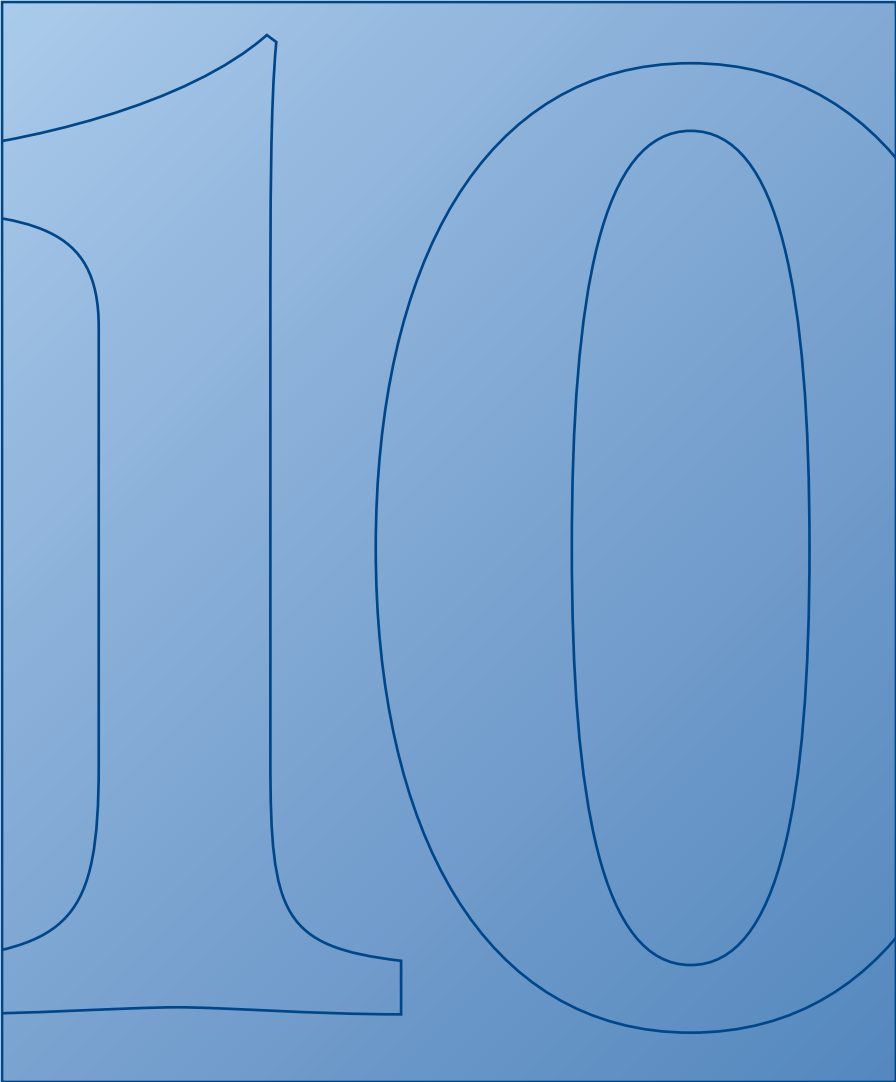


**9. Know what your kids are watching, reading, and listening to.** Television, radio, movies, music videos, magazines, and the Internet are chock full of material sending the wrong messages. Sex rarely has meaning, unplanned pregnancy seldom happens, and no one who is having sex ever seems to be married or even especially committed to anyone. Is this consistent with your expectations and values? If not, it is important to talk with your children about what the media portray and what you think about it. If certain programs or movies offend you, say so, and explain why. Be media literate— think about what you and your family are watching and reading. Encourage your kids to think critically: ask them what they think about the programs they watch and the music they listen to.

You can always turn the TV off, cancel subscriptions, and place certain movies off limits. You will probably not be able to fully control what your children see and hear, but you can certainly make your views known and control your own home environment.

**10. These first nine tips for helping your children avoid teen pregnancy work best when they occur as part of a strong, close relationship with your children, that is built from an early age.** Strive for a relationship that is warm in tone, firm in discipline, and rich in communication and one that emphasizes mutual trust and respect. There is no single way to create such relationships, but the following habits of the heart can help:

- » **Express love and affection clearly and often. Hug your children, and tell them how much they mean to you. Praise specific accomplishments, but remember that expressions of warmth and love should be offered freely, not just for a particular achievement.**
- » **Listen carefully to what your children say and pay thoughtful attention to what they do.**
- » **Spend time with your child engaged in activities that suit his age and interests, not just yours. Shared experiences build a “bank account” of affection and trust that forms the basis for future communication with him about specific topics, including sexual behavior.**
- » **Be supportive and be interested in what interests them. Attend her sports events; learn about his hobbies; be enthusiastic about her achievements, even the little ones; ask them questions that show you care and want to know what is going on in their lives.**
- » **Be courteous and respectful to your children and avoid hurtful teasing or ridicule. Don’t compare your teenager with other family members (i.e., why can’t you be like your older sister?). Show that you expect courtesy and respect from them in return.**
- » **Help them to build self-esteem by mastering skills; remember, self-esteem is earned, not given, and one of the best ways to earn it is by *doing* something well.**
- » **Try to have meals together as a family as often as possible, using the time for conversation, not confrontation.**



**A final note: it's never too late to improve a relationship with a child or teenager. Don't underestimate the great need that children feel — at all ages — for a warm relationship with their parents and for their parents' guidance, approval, and support.**







## The National Campaign

to Prevent Teen and Unplanned Pregnancy

The National Campaign's goal is to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation. Our specific strategy for reaching this goal is to prevent teen pregnancy and unplanned pregnancy among single, young adults. We support a combination of responsible values and behavior by both men and women and responsible policies in both the public and private sectors.

If we are successful, child and family well-being will improve. There will be less poverty, more opportunities for young men and women to complete their education or achieve other life goals, fewer abortions, and a stronger nation.

## Adolescent Sexual Development

STAGE	FACTS	TIPS
<p style="text-align: center;"><b>EARLY ADOLESCENCE</b></p> <p>Females: 9-13 years Males: 11-15 years</p>	<ul style="list-style-type: none"> <li>▶ Puberty/Concern with body changes and privacy.</li> <li>▶ Development of first crush as a milestone to sexual orientation.</li> <li>▶ Concrete thinking, but beginning to explore new ability to think abstractly.</li> <li>▶ Sexual fantasies are common.</li> <li>▶ Masturbation is common.</li> <li>▶ Movement towards defining sexual identity.</li> <li>▶ Sexual intercourse is not common. 4.9% of high school females and 13.5% of high school males had first intercourse before the age of 13.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>▶ Begin discussing healthy relationships using examples from friendships or concepts such as, “what are you looking for in a friend?”</li> <li>▶ Focus on current issues facing the teen instead of future possibilities. Relate decision-making techniques to everyday situations instead of having him/her visualize what may happen in the future. Avoid asking questions framed with “why.”</li> <li>▶ Use health education materials with lots of pictures and simple explanations. Typically, males are not receiving as much information about puberty and body development as girls at this age.</li> <li>▶ Focus on issues that most concern this age group (weight gain, acne, physical changes).</li> </ul>
<p style="text-align: center;"><b>MIDDLE ADOLESCENCE</b></p> <p>Females: 13-16 years Males: 15-17 years</p>	<ul style="list-style-type: none"> <li>▶ Increasing concern with appearance.</li> <li>▶ Peer influences are very strong in decision making.</li> <li>▶ Experimentation with relationships and sexual behaviors is common.</li> <li>▶ Concerned about relationships.</li> <li>▶ Sexual intercourse is increasingly common. 44% of high school tenth graders and 56% of high school eleventh graders have had sexual intercourse.<sup>2</sup></li> <li>▶ Increased abstract thinking ability.</li> <li>▶ Full physical maturation is attained.</li> <li>▶ Dating is common.</li> <li>▶ Sexual behaviors do not always match sexual orientation.</li> <li>▶ Often aware of theoretical risk but do not see self as susceptible.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Listen more and talk less.</li> <li>▶ Help teens identify the characteristics of a healthy relationship and assess their own relationship quality.</li> <li>▶ Peer counseling can be effective with this age group.</li> <li>▶ Focusing on health promotion, prevention and harm reduction is key.</li> <li>▶ Avoid making assumptions about sexual orientation and behaviors.</li> <li>▶ Help provide gay and lesbian youth with positive role models and support systems. Assess family response to youth’s sexual orientation.</li> <li>▶ Be aware youth with disabilities, like their non-disabled peers, may be engaging in sexual behaviors and have questions around their sexual orientation</li> <li>▶ Reinforce parent-child communication about sexual decision making and forming healthy relationships.</li> </ul>
<p style="text-align: center;"><b>LATE ADOLESCENCE</b></p> <p>Females: 16-21 years Males: 17-21 years</p>	<ul style="list-style-type: none"> <li>▶ Firmer and more cohesive sense of identity.</li> <li>▶ Attainment of abstract thinking.</li> <li>▶ Ability to establish mutually respectful/trusting relationships.</li> <li>▶ Firmer sense of sexual identity.</li> <li>▶ Concern for the future.</li> <li>▶ Feelings of love and passion.</li> <li>▶ Increased capacity for tender and sensual love.</li> </ul>	<ul style="list-style-type: none"> <li>▶ More abstract reasoning allows for more traditional counseling approaches.</li> <li>▶ Acknowledge and support healthy relationships or the choice to not be in a relationship.</li> </ul>

<sup>1</sup>Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-US 2007. *Morbidity and Mortality Weekly Report*. 2008; 55(SS-4).

<sup>2</sup>Ibid.



## When Sexual Intercourse\* with a Minor Must Be Reported as Child Abuse by Mandated Reporters: California Law

The California Child Abuse and Neglect Reporting Act requires certain professionals (“mandated reporters”), like teachers and health care providers, to report to child protection or law enforcement when they know or reasonably suspect child abuse. Sexual intercourse with a minor (a person younger than age 18) is reportable as child abuse in three circumstances:

### 1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report if they have a reasonable suspicion that intercourse with a minor was coerced or in any other way not voluntary. As one example, sexual activity is not voluntary when the victim is unconscious or so intoxicated that he or she cannot resist. *See* Penal Code sections 261 and 11165.1 for more examples.

### 2. WHEN IT INVOLVES SEXUAL EXPLOITATION OR TRAFFICKING

Mandated reporters must report if they have a reasonable suspicion that a minor has been sexually trafficked or is being sexually exploited. See [www.teenhealthlaw.org](http://www.teenhealthlaw.org) for more information on this requirement.

### 3. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND MINOR IN A FEW SITUATIONS

Mandated reporters also must report intercourse with a minor in a few situations based solely on the age difference between the minor and their partner, according to the following chart:

**KEY: M = Mandated.** A report is mandated based solely on age difference between partner and minor.

**J = Use judgment.** A report is not mandated based solely on age difference; however, a reporter must report if he or she has a reasonable suspicion that the intercourse was coerced, involved trafficking or exploitation, or was in any other way not voluntary, as described above, irrespective of age..

Age of Partner ⇒ Age of Youth ↓	12	13	14	15	16	17	18	19	20	21	22 & older
11	J	J	M	M	M	M	M	M	M	M	M ⇒
12	J	J	M	M	M	M	M	M	M	M	M ⇒
13	J	J	M	M	M	M	M	M	M	M	M ⇒
14	M	M	J	J	J	J	J	J	J	M	M ⇒
15	M	M	J	J	J	J	J	J	J	M	M ⇒
16	M	M	J	J	J	J	J	J	J	J	J ⇒
17	M	M	J	J	J	J	J	J	J	J	J ⇒
18	M	M	J	J	J	J	Chart design by David Knopf, LCSW, UCSF. (The legal sources for this chart are: Penal Code §§ 261.5, 261, 11165.1, 11165.6, 11166; 249 Cal. Rptr. 762, 769 (3 <sup>rd</sup> Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1 <sup>st</sup> Dist. Ct. App. 1986).				
19	M	M	J	J	J	J					
20	M	M	J	J	J	J					
21 & older	M	M	M	M	J	J					

### Do I have a duty to ascertain the age of a minor’s sexual partner for the purpose of child abuse reporting?

No statute or case obligates mandated reporters to ask youth about the age of their sexual partners for the purpose of reporting child abuse. *See* 249 Cal. Rptr. 762, 769 (3<sup>rd</sup> Dist. Ct. App. 1988).

### Do I report pregnancy as child abuse?

The Child Abuse and Neglect Reporting Act states that “the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of child abuse.” Penal Code section 11166(a)(1).

### What do I do if I am not sure whether I should report something?

When you aren’t sure whether a report is required or warranted, you may consult with legal counsel and Child Protective Services to ask about the necessity or appropriateness of a referral.

\* This worksheet addresses mandated reporting of vaginal intercourse between non-family members. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California, check [www.teenhealthlaw.org](http://www.teenhealthlaw.org). Legal information, not legal advice. © National Center for Youth Law. June 2017.



CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**

744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

September 30, 2016

ALL COUNTY LETTER NO. 16-82

TO: ALL COUNTY CHILD WELFARE DIRECTORS  
 ALL COUNTY CHILD WELFARE PROGRAM MANAGERS  
 ALL CHIEF PROBATION OFFICERS  
 ALL FOSTER FAMILY AGENCY DIRECTORS  
 ALL GROUP HOME DIRECTORS  
 ALL TITLE IV-E AGREEMENT TRIBES  
 ALL ADOPTION REGIONAL AND FIELD OFFICES  
 ALL JUDICIAL COUNCIL STAFF

SUBJECT: REPRODUCTIVE AND SEXUAL HEALTH CARE AND RELATED RIGHTS FOR YOUTH AND NON-MINOR DEPENDENTS (NMD) IN FOSTER CARE

REFERENCE: SENATE BILL [528](#) (CHAPTER 338, STATUTES OF 2013); WELFARE AND INSTITUTIONS CODE (W&IC) SECTIONS [369](#), [16001.9](#), [16002.5](#) AND [16521.5](#) ; ALL COUNTY LETTERS (ACL) [02-54](#), [08-51](#) AND [14-38](#); ALL COUNTY INFORMATION NOTICE [1-60-15](#)

The purpose of this ACL is to provide county child welfare agencies, probation departments and other relevant parties with information and guidance related to legislative changes and existing law on the reproductive and sexual health care and related rights of youth and Non-Minor Dependents (NMDs) in foster care. Unless otherwise noted, references to foster youth in this ACL include NMDs, as well as wards who are the subject of a petition filed pursuant to the W&IC section 602.

**Background**

Researchers at the Chapin Hall, University of Chicago, interviewed approximately 2,500 current and former foster youth who had resided in 51 of California’s 58 counties. This research, reported in the *California Youth Transitions to Adulthood (Cal YOUTH)*, found that approximately 27 percent of young women and 10 percent of young men reported

having a child by the age of 19. According to the study, 49.3 percent of female youth had experienced a pregnancy by 20 years-of-age. When female youth were asked about their desire to become pregnant, about one-third reported they definitely did not want to have a baby and more than one-quarter said they did not want to become pregnant at that time. In a 2013 publication entitled "*California's Most Vulnerable Parents: When Maltreated Children Have Children*," it was reported that more than a third of California young women who grew up in foster care were mothers by age 21.

### **Reproductive and Sexual Health Care and Related Rights for Youth and NMDs in Foster Care**

Youth and NMDs in foster care are entitled to certain reproductive and sexual health care rights. It is important that foster youth and the parties who serve these youth, such as county social workers, probation officers, Court Appointed Special Advocates, foster family agency and group home staff, caregivers and other service providers are aware of these rights and respect the youth's exercise of their rights.

County social workers and probation officers shall inform foster youth in a manner appropriate to the age or developmental level of the youth of their rights, including their reproductive and sexual health care rights, upon entry into foster care and at least once every six months at the time of a regularly scheduled placement agency contact.<sup>1</sup> County social workers and probation officers shall provide youth and NMDs with access to age-appropriate, medically accurate information about sexual development, reproductive and sexual health care, the prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and the prevention and treatment of sexually transmitted infections (STIs).<sup>2</sup> Care providers, such as foster parents and group home providers, in consultation with the county social worker or probation officer, shall be responsible for ensuring that adolescents including NMDs, who remain in long-term foster care, receive age-appropriate, medically accurate, culturally sensitive pregnancy prevention information.<sup>3</sup>

The following is a list of certain reproductive and sexual health care and related rights that foster youth have and are entitled to have respected, which are within the oversight and enforcement authority of the California Department of Social Services, as well as citations to various laws that pertain to these rights:

1. The right to receive medical services, including reproductive and sexual health care.<sup>4</sup>

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<sup>1</sup> W&IC section 16501.1, subdivision (g)(4).

<sup>2</sup> W&IC sections 369(h) and 16001.9, subdivision (a)(27).

<sup>3</sup> W&IC section 16521.5, subdivision (a).

<sup>4</sup> W&IC section 16001.9, subdivision (a)(4).

2. The right to consent to or decline medical care (without need for consent from a parent, caregiver, guardian, social worker, probation officer, court, or authorized representative) for:<sup>5</sup>
  - a) The prevention or treatment of pregnancy, including contraception, at any age<sup>6</sup>, (except sterilization).<sup>7</sup>
  - b) An abortion, at any age.<sup>8</sup>
  - c) Diagnosis and treatment of sexual assault, at any age.<sup>9</sup>
  - d) The prevention, diagnosis, and treatment of STIs, at age 12 or older.<sup>10</sup>

If the foster youth has the right to personally consent to medical services, such services shall be provided confidentially and maintained as confidential between the provider and foster youth to the extent required by the Health Insurance Portability and Accountability Act and the California Confidentiality of Medical Information Act,<sup>11</sup> unless disclosed through written consent of the foster youth or through a court order. When a youth has the right to consent, there shall be privacy for examination or treatment by a medical provider, unless the youth specifically requests otherwise.<sup>12</sup>

3. The right to have access to age-appropriate, medically accurate information about reproductive and sexual health care, the prevention of unplanned pregnancy including abstinence and contraception, abortion care, pregnancy services, and the prevention, diagnosis, and treatment of STIs, including but not limited to the availability of the Human Papillomavirus (HPV) vaccination.<sup>13</sup>
4. The right to be provided transportation to reproductive and sexual health-related services.<sup>14</sup>

Many reproductive health services are time-sensitive (e.g. emergency contraception, abortion); therefore, transportation must be provided in a timely manner in order to meet the requirement.

5. The right to obtain, possess and use the contraception of his or her choice, including condoms.<sup>15</sup>

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<sup>5</sup> W&IC section 369, subdivision. (h). The NMDs have the medical consent rights of other adults, W&IC section 303, subdivision (d).

<sup>6</sup> Family Code section 6925.

<sup>7</sup> Family Code section 6925, subdivision (b)(1).

<sup>8</sup> Family Code section 6925; The right to consent to an abortion at any age was established by the California Supreme Court in *American Academy of Pediatrics v. Lungren* (1997) 16 Cal.4th 307.

<sup>9</sup> Family Code section 6928, subdivision (b).

<sup>10</sup> Family Code section 6926, subdivision (b).

<sup>11</sup> Public Law 104-191, Civil Code section 56 et seq., See, Health & Safety Code, sections 123110 and 123115.

<sup>12</sup> Id.

<sup>13</sup> W&IC sections 16001.9, subdivision (a)(27) and 369, subdivision (h).

<sup>14</sup> W&IC section 16001.9, subdivision (a)(4); Title 22 California Code of Regulations (CCR) sections 8075, subdivision (a) and 89374, subdivision (c)(1).

6. The right to have private storage space and to be free from unreasonable searches of his or her personal belongings.<sup>16</sup> Contraception cannot be taken away as part of a group home discipline program or for religious beliefs, personal biases and judgments of another person.<sup>17</sup>
7. The right to choose his or her own health care provider, if payment for the health service is authorized under applicable Medicaid law.<sup>18</sup>
8. The right to fair and equal access to all available services, placement, care, treatment and benefits, and to not be subjected to discrimination or harassment based on actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or Human Immunodeficiency Virus (HIV) status.<sup>19</sup>
9. The right to independently contact state agencies, including the Community Care Licensing Division of the California Department of Social Services and the state Foster Care Ombudsperson, regarding violations of rights, to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints.<sup>20</sup>
10. Depending on the type of licensed home or facility and age of the foster youth, personal rights are to be posted and/or explained in an age or developmentally appropriate manner, and provided to the foster youth.<sup>21</sup>

For questions regarding the content of this letter, please contact the Placement Services and Support Unit at (916) 657-1858 or via email at [SexualDevWorkgroup@dss.ca.gov](mailto:SexualDevWorkgroup@dss.ca.gov).

Sincerely,

**Original Document Signed By:**

GREGORY E. ROSE  
Deputy Director  
Children and Family Services Division

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<sup>15</sup> Family Code section 6925 and W&IC section 369, subdivision. (h).

<sup>16</sup> W&IC section 16001.9, subdivision (a)(18) and subdivision (a)(21).

<sup>17</sup> Title 22 CCR section 84072, subdivision (c)(9).

<sup>18</sup> 42 United States Code sections 1396a, subdivision (23)(B) and 1396n, subdivision (b).

<sup>19</sup> W&IC section 16001.9, subdivision (a)(23).

<sup>20</sup> W&IC section 16001.9, subdivision (a)(8).

<sup>21</sup> W&IC section 16001.9 and Title 22 CCR sections 83072, 84072, 86072 and 89372.



## California Sexual and Reproductive Health Care Programs

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents. **These include:**

**Mandatory comprehensive sexual health education** in public middle and high schools

**Consent rights** that allow adolescents who need it to confidentially access care

A network of clinics that provide **sexual health services** to address adolescent needs

**Public funding streams** for sexual health services to ensure free access

**Trustworthy information** for teens and adult caregivers



In California, the availability of three different public funding programs means that **a full range of sexual and reproductive health services is available to adolescents at no cost.**

**Medi-Cal**

**Family PACT**

**Title X**

### Medi-Cal

Standard of Care: California has adopted the **AAP Bright Futures Guidelines** as the standard of care in the state Medi-Cal program. Bright Futures recommends the following:

- Requires annual health visits for teens
- Recommends confidential time with the provider at each health maintenance visit to discuss sexuality, sexual health promotion, and risk reduction
- Includes coverage for anticipatory guidance, referrals and follow ups for sexual health as necessary



#### Covered Services:

- When services are necessary, Medi-Cal covers **confidential family planning, prenatal care, abortion, and STI services for adolescents for free** with no co-pays.

#### Provider Choice:

- Federal Medicaid regulations, which apply to California's Medi-Cal program, allow patients to choose their **provider of choice** for sexual and reproductive health care (i.e. they are not required to see primary care physician for these services if they prefer another provider).
- There is **no need for referral from primary care** – patients can go directly to a sexual and reproductive health specialist for care.

For more information on Bright Futures: <https://brightfutures.aap.org/states-and-communities/Pages/California.aspx>

For more information on Medi-Cal: NHeLP, *Reproductive Health Care Coverage in Medi-Cal*, <http://www.healthlaw.org/storage/documents/NHeLP-ReproHC-MediCal-Web-F.pdf>

### Family PACT

The **California Office of Family Planning (OFP)** is charged by the California Legislature “to make available to citizens of the State who are of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families”.

- The OFP administers the **Family Planning, Access, Care, and Treatment (Family PACT) program**. Family PACT is California's innovative approach to provide comprehensive



family planning services to eligible low income (under 200% federal poverty level) Californians.

#### Covered Services:

- Services include **comprehensive education, assistance, and services relating to family planning.**
- Family PACT benefits include all FDA-approved contraceptive methods and supplies, STI testing and treatment, HIV screening, and cervical cancer screening.
- **There are over 2,200 public and private Family PACT providers in California.**

For more information on Family PACT: <http://www.familypact.org/Home/home-page>

## **Title X Family Planning**

The **federal Title X program** funds family planning services for individuals of childbearing age, including adolescents. It is the nation's only dedicated source of federal funding for family planning services.

#### Administration:

- Title X is administered by the national Office of Population Affairs (OPA), which provides funding to **Essential Access Health (EAH)** to re-grant to health care providers throughout California.
- Throughout California, Title X serves nearly 1,000,000 women, men and teens through
  - **61 health care organizations** operating nearly
  - **356 health centers** in
  - **37 of California's 58 counties.**
- EAH has an online clinic finder map available at [www.TeenSource.org](http://www.TeenSource.org).



#### Covered Services:

- Title X-funded health centers must provide a **range of confidential preventive health services** including contraceptive services, pregnancy testing, pelvic exams, screening for breast and cervical cancer, screening for STDs including HIV/AIDS, basic infertility services, health education and referrals for other health and social services.
- Title X funds also support critical activities that are not reimbursable under Medi-Cal or commercial insurance, such as staff salaries, infrastructure improvements, individual patient education, and community outreach.

#### Coordination of Care:

- **Title X and the Family PACT program in California are coordinated** to ensure comprehensive and available care.
- Title X funds outreach and education and connects individuals to health centers, while Family PACT provides direct reimbursement to clinics.
- This combination has reduced unintended pregnancy rates in California by over 70% since the 1990's.

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### Birth Control for Adolescents

- Public and private insurance must pay for **all methods of birth control**, including emergency contraception
- Birth control **must be free** (no co-pays!)
- Adolescents can request a **12-month supply** of pills, patches, and rings at one time
- **Free condoms** for adolescents through the Condom Access Project
  - Youth can request free condoms or find locations to pick them up at: [www.teensource.org/condoms/free](http://www.teensource.org/condoms/free)
- Minors **of all ages** have a right to consent to and to confidentiality in services.

### STI Screening and Services for Adolescents

- Most public and private insurance must pay for recommended screening and prevention with no co-pay, including the HPV and Hepatitis B vaccines.
- STI screening and services are available with no co-pays.
- **Free condoms** for adolescents through the Condom Access Project. Information at: <http://www.teensource.org/condoms/free>
- MediCal Minor Consent covers PrEP for minors with no co-pay. PrEP is a pre-exposure prophylactic medication that reduces the risk of HIV infection.
- Minors 12 and older have a right to consent to and to confidentiality in services.

### Pregnancy Testing, Prenatal Care and Abortion for Adolescents

- Testing and services with no co-pay
- MediCal covers prenatal, postnatal, abortion and related services, such as ultrasound, with no co-pay.
- Insurance must ensure timely access to providers.
- Minors **of all ages** have a right to consent to and to confidentiality in services.

**Teens can find sexual and reproductive health clinic referrals, including referrals for no-cost care at:**  
<http://www.teensource.org/find-a-clinic>

Sources: NHeLP, *Reproductive Coverage in Medi-Cal*, at <http://www.healthlaw.org/storage/documents/NHeLP-ReproHC-MediCal-Web-F.pdf>; Access and NHeLP, *California Abortion Coverage in Medi-Cal and Private Insurance*, at <http://accesswhj.org/sites/default/files/docs/NHeLP-CAAbortionCoverageFactSheet-Web.pdf>; KFF, *Payment and Coverage for the Prevention of Sexually Transmitted Infections*, at <https://www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-stis>

## California Sexual and Reproductive Health Care Information

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There are many resources for adolescents and adult caregivers regarding sexual and reproductive health care.

Federal and state funding pays for **online resources**, including content from state agencies and **Essential Access Health**, the agency that administers federal Title X funding in California.

### Resources from Essential Access Health

- [www.TeenSource.org](http://www.TeenSource.org)
  - Clinic referral tool
  - Youth-friendly information on birth control, STIs, relationships, and rights under California law
- Text messaging service called “The Hookup” provides weekly sexual health information. Texting a zip code to the service will identify a nearby clinic that can provide low to no cost sexual health services.
  - More information at: <http://www.teensource.org/hookup>
- [www.TalkWithYourKids.org](http://www.TalkWithYourKids.org)
  - Information for caring adults on how to talk with teens about sexual health care and healthy relationships
- <https://www.essentialaccess.org/learning-exchange>
  - National resource for health professional in primary care, private practice, family planning and women’s health settings seeking to learn and share best practices in sexual and reproductive health care service delivery

### State Resources

- <http://www.familypact.org/Clients/education-materials>
  - Education materials for patients on birth control methods, STIs, reproductive coercion and intimate partner violence, and breast and cervical cancer screening
- <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Communications/Profile-IE.pdf>
  - In-person information and education programs from the California Department of Public Health
- <http://californiaptc.com/sexual-health-educator-training-program/>
  - Free training program for educators in school, community, and clinic settings who want to build their knowledge and capacity in sexual health and sexuality education
  - In-person and online training topics include: STD/HIV review, contraceptive methods, minor consent and confidentiality, STD data, California education code, and more

## California Sexual and Reproductive Health Care Services

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents.

**These include:**

**Mandatory comprehensive sexual health education in public middle and high schools**

**Consent rights** that allow adolescents who need it to confidentially access care

A network of clinics that provide **sexual health services** to address adolescent needs

**Public funding streams** for sexual health services to ensure free access

**Trustworthy information** for teens and adult caregivers



State law requires public middle and high schools to provide comprehensive sexual health education that complies with the standards established by the California Healthy Youth Act (CHYA)(Education Code section 51930 through 51939). Senate Bill 89 ensures that (1) foster youth receive **comprehensive sexual health education** at least once during middle school and at least once during high school (2) using educational curricula that meets the requirements of **CHYA**.

### California Healthy Youth Act (CHYA)

#### What purposes must a CHYA compliant educational curriculum serve?

To satisfy the California Healthy Youth Act, the curriculum must have the following purposes:

1. To provide pupils with the knowledge and skills necessary to protect their sexual and reproductive health from HIV and other sexually transmitted infections and from unintended pregnancy.
2. To provide pupils with the knowledge and skills they need to develop healthy attitudes concerning adolescent growth and development, body image, gender, sexual orientation, relationships, marriage, and family.
3. To promote understanding of sexuality as a normal part of human development.
4. To ensure pupils receive integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention instruction and provide educators with clear tools and guidance to accomplish that end.
5. To provide pupils with the knowledge and skills necessary to have healthy, positive, and safe relationships and behaviors.

*From Cal. Education Code section 51930*

#### What content requirements must a CHYA compliant educational curriculum satisfy?

To satisfy the California Healthy Youth Act, the curriculum must satisfy the following requirements:

1. Instruction and materials shall be **age appropriate**.
2. All factual information presented shall be **medically accurate and objective**.
3. All instruction and materials shall align with and support the purposes of the California Healthy Youth Act (described above) and may not be in conflict with them.
4. Instruction and materials shall be **appropriate** for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners.

5. Instruction and materials shall be made **available on an equal basis** to a pupil who is an English learner, consistent with the existing curriculum and alternative options for an English learner pupil as otherwise provided in this code.
6. Instruction and materials shall be **accessible to pupils with disabilities**, including, but not limited to, the provision of a **modified curriculum, materials and instruction** in alternative formats, and auxiliary aids.
7. Instruction and materials **shall not reflect or promote bias** against any person on the basis of any category protected by Section 220.
8. Instruction and materials shall **affirmatively recognize that people have different sexual orientations** and, when discussing or providing examples of relationships and couples, shall **be inclusive of same-sex relationships**.
9. Instruction and materials shall **teach pupils about gender, gender expression**, gender identity, and **explore the harm of negative gender stereotypes**.
10. Instruction and materials shall encourage a pupil to **communicate** with his or her parents, guardians, and other **trusted adults** about human sexuality and provide the knowledge and skills necessary to do so.
11. Instruction and materials shall teach the value of and prepare pupils to have and maintain **committed relationships** such as marriage.
12. Instruction and materials shall provide pupils with **knowledge and skills they need to form healthy relationships** that are based on mutual respect and affection, and are free from violence, coercion, and intimidation.
13. Instruction and materials shall provide pupils with knowledge and skills for making and implementing **healthy decisions about sexuality, including negotiation and refusal skills** to assist pupils in overcoming peer pressure and using effective decisionmaking skills to avoid high-risk activities.
14. Instruction and materials **may not teach or promote religious doctrine**.

*From Cal. Education Code section 51933*

**This instruction shall include all of the following:**

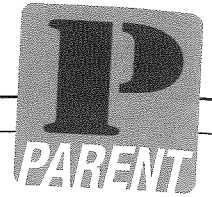
- Information on the nature of HIV, as well as other sexually transmitted infections, and their effects on the human body.
- Information on the manner in which HIV and other sexually transmitted infections are and are not transmitted, including information on the relative risk of infection according to specific behaviors, including sexual activities and injection drug use.
- Information that abstinence from sexual activity and injection drug use is the only certain way to prevent HIV and other sexually transmitted infections and abstinence from sexual intercourse is the only certain way to prevent unintended pregnancy. Instruction shall provide information about the value of delaying sexual activity while also providing medically accurate information on other methods of preventing HIV and other sexually transmitted infections and pregnancy.
- Information about the effectiveness and safety of all federal Food and Drug Administration (FDA) approved methods that prevent or reduce the risk of contracting HIV and other sexually transmitted infections, including use of antiretroviral medication, consistent with the federal Centers for Disease Control and Prevention.
- Information about the effectiveness and safety of reducing the risk of HIV transmission as a result of injection drug use by decreasing needle use and needle sharing.
- Information about the treatment of HIV and other sexually transmitted infections, including how antiretroviral therapy can dramatically prolong the lives of many people living with HIV and reduce the likelihood of transmitting HIV to others.
- Discussion about social views on HIV and AIDS, including addressing unfounded stereotypes and myths regarding HIV and AIDS and people living with HIV. This instruction shall emphasize that successfully treated HIV-

positive individuals have a normal life expectancy, all people are at some risk of contracting HIV, and the only way to know if one is HIV-positive is to get tested.

- Information about local resources, how to access local resources, and pupils' legal rights to access local resources for sexual and reproductive health care such as testing and medical care for HIV and other sexually transmitted infections and pregnancy prevention and care, as well as local resources for assistance with sexual assault and intimate partner violence.
- Information about the effectiveness and safety of all FDA-approved contraceptive methods in preventing pregnancy, including, but not limited to, emergency contraception. Instruction on pregnancy shall include an objective discussion of all legally available pregnancy outcomes, including, but not limited to, all of the following:
  - Parenting, adoption, and abortion.
  - Information on the law on surrendering physical custody of a minor child 72 hours of age or younger, pursuant to Section 1255.7 of the Health and Safety Code and Section 271.5 of the Penal Code.
  - The importance of prenatal care.
- Information about sexual harassment, sexual assault, adolescent relationship abuse, intimate partner violence, and sex trafficking.

*From Cal. Education Code section 51934*

For questions or more information about Senate Bill 89 and foster youth access to comprehensive sexual health education, please contact the **Los Angeles Reproductive Health Equity Project for Foster Youth** (LA RHEP) at [www.fosterreprohealth.org](http://www.fosterreprohealth.org).



## **YOUR TEEN IS CHANGING!**

The teen years are a time of growth and change as your teen moves from being a child to an adult.

As your teen changes, your role as a parent changes. You will relate to your 12 year old differently than your 18 year old. It is important to know what to expect, so that you can give your teen more responsibility and the best possible advice.

### **YOUR TEEN MIGHT:**

- Become more independent
- Want more responsibility
- Push boundaries and test limits
- Want their relationship with you to change
- Need more privacy
- Have mood swings
- Think a lot more about their own personal concerns
- Place more importance on friends
- Feel that no one understands them
- Tryout new behaviors and activities – both healthy and risky
- Understand complicated concepts instead of just the here and now

### **YOUR TEEN STILL NEEDS YOU TO:**

- Give them your time
- Give them a sense of connection or belonging
- Support them
- Provide for their basic needs
- Guide them
- Express your love
- Set limits
- Pay attention to their successes and behaviors
- Be involved and aware of what is going on in their lives

### **REMEMBER:**

All of these changes are perfectly normal! Your teen still needs you, but may not always know how to communicate that. You are still the best person to guide your teen, and it is important to keep talking with them.

Talk to your teen's doctor or nurse about these changes and any challenges you may have with your teen.

### **WEBSITES FOR PARENTS:**

#### **RESOURCES**

**Children Now and Kaiser Family Foundation**

<http://www.talkingwithkids.org>

**Advocates for Youth**

<http://www.advocatesforyouth.org/>

**SIECUS– Families are Talking**

<http://www.familiesaretalking.org>

**California Family Health Council–Talk with Your Kids**

<http://www.talkwithyourkids.org/>

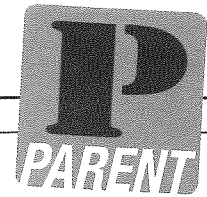
**US Department of Health & Human Services–  
Parents Speak Up**

<http://www.4parents.gov/>

**Nickelodeon–Parents Connect**

<http://www.parentsconnect.com>





## **KNOW MYSELF, KNOW MY TEEN**

*Sometimes your opinions can stand in the way of listening to your teen with an open mind. If teens feel judged by their parents or guardians, they are less likely to share information that may be sensitive, embarrassing, or hard to talk about. Ask yourself these questions before you talk about sensitive issues with your teen.*

### ***How do I feel?***

What is your mood? What are the memories that may shape your opinions? Keep in mind that what you went through as a teen may be different from what your teen is going through now.

### ***What was I doing when I was 16?***

Have you thought about what you want to share with your teen? Hold off on sharing sensitive information with your teen until he/she is in the middle teen years.

### ***Are we finding some time together to enjoy each other?***

It may be hard to believe, but most teens say they wish they had more time with their parents. Difficult topics may be easier to talk about when you spend enjoyable times together like going for walks, watching movies, doing projects, or sharing meals.

### ***Am I listening to my teen?***

Spend as much time listening as you do talking. Avoid making quick judgments. If you do not understand what your teen is trying to say, repeat what they have said back to them.

### ***Do I judge too quickly?***

Always ask your teen what she or he is doing rather than thinking the worst. Trust that he or she can make good decisions.

### ***What are my rules about safety?***

Tell your teen which rules must be followed for his or her safety. Follow through with consequences if your teen behaves in unsafe ways. Talk about the importance of safety on a regular basis, not only once. Get help immediately if your teen is in an unsafe situation.

### ***Am I willing to get help for any problems I may have?***

It is important to be an example for your teen. Seeing family members get help will encourage your teen to get help for his or her own problems.



Adapted with permission from "Are you An Askable Parent?" Advocates for Youth, Washington, DC. [www.advocatesforyouth.org](http://www.advocatesforyouth.org)

# How to Talk with Your Children and Teens about Healthy Relationships

- ◆ Talk to your children and teens about friendship, dating, and love *before* they start to ask questions about these important issues.
- ◆ Listen to your children and teens and try to understand their point of view.
- ◆ If you can't answer a question, help your children talk to other trusted adults.
- ◆ Use daily experiences like watching TV, to talk with your children and teens. It is a chance to share your values and messages with them.
- ◆ Find out what schools are teaching your children and teens about these topics.
- ◆ Stay active in the lives of your children and teens and help them plan for the future.



## Know and practice the messages that you want to share with your children and teens.

*Use the information below to make your messages clear.*

### Message Information For Ages 12-15:

- ◆ Friends can influence each other in positive and negative ways.
- ◆ People can be friends without being sexual.
- ◆ People are ready to start dating at different times.
- ◆ When couples spend a lot of time together alone, they are more likely to become sexually involved.
- ◆ If someone pays for a date or gives gifts, it does not mean that they are owed sexual activity.
- ◆ In a love relationship, people help each other to grow as individuals.
- ◆ People may mix up love with other strong emotions like jealousy and control.

### Message Information For Ages 15-18:

- ◆ Dating can be a way to learn about other people and what it is like to be in a love relationship. It is also a way to learn about romantic and sexual feelings.
- ◆ Being honest and open can make a relationship better.
- ◆ Both people in the relationship are responsible for it.
- ◆ A dating partner cannot meet all of the needs of another person.
- ◆ A lot of time, love changes during a long term relationship.

Keep these talks going! When you talk about relationships with your teen, you can hear about what is going on in your teen's life. You can also teach your teen about your family's values and beliefs.

Adapted from SEICUS. Families Are Talking; Volume 3, Number 1, 2004.

# Should I Worry About My Teen?

### The Facts about Teen Dating Violence:

*Teen dating violence is when a teen:*

- ⇒ Hits, punches, slaps, or kicks their partner.
- ⇒ Forces or pressures their partner to have sex.
- ⇒ Teases, controls, or intimidates their partner.
- ⇒ Isolates their partner from friends and family.
- ⇒ Stops their partner from doing normal activities.

### Warning signs for Teen Dating Violence

*Know the warning signs of when a teen is being abused or is abusing others. Ask yourself the following questions:*

#### Has your teen or your teen's dating partner...

- ▶ Lost interest in activities that used to be enjoyable?
- ▶ Stopped hanging out, talking on the phone, or staying in contact with friends?
- ▶ Acted extremely jealous?
- ▶ Violently lost their temper and hit or broke objects?
- ▶ Tried to control their partner's behavior?
- ▶ Check up constantly on their partner and demand to know who their partner is with?
- ▶ Had a sudden change in weight, appearance, or school performance?
- ▶ Had injuries that cannot be explained, or gave an explanation that did not make sense?

**If you notice any of the above warning signs, talk with your teen about his/her relationship. Try and stay supportive and non-judgmental. Contact a domestic violence agency or call 1-800-799-SAFE for advice on the situation.**

#### Did you know there are ways to prevent teen dating violence? Here are some of the things that help:

- Talk to your teen about their friends and relationships.
- Listen to your teen and be open to their experiences.
- Support your teen in pursuing their interests.
- Help your teen get involved in school and after school programs such as clubs and sports.
- Encourage your teen to join religious, spiritual, or community groups.
- Assist your teen with volunteering in the community.

Source:

Liz Claiborne, Inc, National Teen Dating Violence Helpline, Love Is Respect.org: A Parent's Guide to Dating Violence: Questions to Start the Conversation.

# ***A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention***

## Introduction

In February of 2016, the California Department of Social Services (CDSS) along with stakeholders, formed the Healthy Sexual Development (HSD) Workgroup. This workgroup met to address concerns regarding youth and Non-Minor Dependents (NMD) in care and their reproductive health. Despite the passage of legislation addressing the reproductive health rights of foster youth, it was clear that there was more guidance needed from CDSS to assist county agencies, case managers, group home staff, caregivers and others who work with foster youth, in understanding this important topic. The HSD Workgroup met several times between the months of February and October of 2016 with a goal of creating a statewide plan for preventing unintended pregnancy among California's foster youth and to create various accompanying materials.

In August of 2016, "California's Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents" was posted via All County letter ([ACL 16-88](#)). This guide is an extension of the plan and expands upon section III, "Role of the Case Management Worker (Social Worker or Probation Officer)." Throughout this guide, unless otherwise noted, all references to "foster youth" include dependents, NMDs and wards of the court placed in foster care.

It is recommended that county agencies create their own supplemental guidance to coincide with this document. This supplemental guidance could include information for case managers about local county practices and procedures, as well as any available resources within the county for youth, such as health centers/clinics, counseling centers, any other social service agencies, and trainings for youth and/or social workers pertaining to this topic.

A new curriculum, as per the passage of Senate Bill (SB) 89, regarding foster youth and reproductive health will be developed in the upcoming months. This curriculum will be made available to foster youth caregivers, county case managers and others who work with foster youth. When this curriculum is available, it will be announced to county agencies via the issuance of an ACL.

For further background related to CDSS' efforts surrounding the healthy sexual development of foster youth, please refer to ACLs [14-38](#), [16-32](#), [16-82](#) and [16-88](#), and All County Information Notices (ACIN) [I-60-15](#), [I-40-16](#), and [I-73-16](#).

## Role of the Case Manager

The case manager serves a crucial role in the foster youth's life, as the case manager is responsible for overseeing that the youth's basic needs are met and personal rights are adhered to.<sup>1</sup> These rights include the foster youth's right to access reproductive and sexual health care, such as timely access to services related to the prevention, testing and treatment of Sexually Transmitted Infections (STIs), unintended pregnancy and other related services, including prenatal care.

Some case managers express concern that they aren't sure what they're "allowed" to talk to youth about in regards to reproductive health and pregnancy prevention. For example, they don't want to talk to youth about birth control options and later find out that the birth parent, child's attorney or other individual is upset by the case manager's actions. Not only are case managers "allowed" to talk to youth about their reproductive health including birth control options, abortion and STIs, they are required to do so. As is stated in "California's Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents," by applying the Reasonable and Prudent Parent Standard when addressing youth concerns and questions, case managers can create normalcy and support the healthy sexual development of youth and NMDs based on their individual needs.<sup>2</sup>

Existing law provides youth and NMDs in foster care with certain reproductive and sexual health care rights. The passage of SB 528 in 2013, added a new right to the personal rights of foster youth. It said that minors and non-minors shall have access to age-appropriate, medically accurate information about reproductive health care, the prevention of unplanned pregnancy, and the prevention and treatment of sexually transmitted infections. Additionally, case managers are required to discuss with youth their personal rights, upon entry into foster care and at least once every six months.

Due to the passage of [SB 89](#) on June 27, 2017, new requirements are in effect regarding child welfare case plans for foster youth who are 10 years-old and older. Case Managers are now required to review the case plan annually and update as needed to ensure the youth receives comprehensive sexual health education through their schools in junior high and high school, or by other means if they have not received it through their school. Case plans also must be updated annually to indicate that case managers have informed youth of their right to access reproductive and sexual health information and services, and how to access such information and services.

Working with foster youth and discussing such personal topics as reproductive health, pregnancy prevention and other sexual matters can be uncomfortable for the case manager, as well as for the youth. Tips for talking with youth about sexual and reproductive health and ways case managers can build rapport with youth are provided in the section of this guide entitled, "Tips for Talking to Teens about Sex and Building Rapport."

This guide is organized in five main sections: [REQUIRED DUTIES OF THE CASE MANAGER](#), [RECOMMENDED DUTIES OF THE CASE MANAGER](#), [TIPS FOR TALKING WITH YOUTH](#), [CASE SCENARIOS](#), AND [ONLINE RESOURCES](#).

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<sup>1</sup> For further information, please see Welfare and Institutions Code section 16001.9a

<sup>2</sup> See ACL 16-31 for guidelines about the Reasonable and Prudent Parent Standard

## **REQUIRED DUTIES OF THE CASE MANAGER**

Required duties and responsibilities are defined for case managers in section III, items A-G in [“California’s Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents.”](#) This Guide for Case Managers expands upon these requirements and provides practical guidance to assist case managers with understanding this work.

### **A. Provide Youth with a Copy of Their Foster Youth Rights**

Case managers shall provide youth with a copy of their Foster Youth Rights upon entry into foster care and at least once every six months at the time of regularly scheduled contact.<sup>3</sup> At the time of providing these rights to foster youth, the case manager will have a conversation with the youth, explaining each of their rights and ensuring the youth understands their rights based on their age and developmental level. As some youth may have special needs or may have a language barrier, the case manager should reference their county’s policies and procedures in obtaining appropriate assistance and/or an interpreter as needed to ensure the youth fully understands their rights. Accordingly, case managers should assist foster youth in understanding their rights at any time the youth may have questions about them, but at a minimum as stated above, these conversations are required to occur at the time the youth enters care and every six months thereafter.

### **B. Provide Youth with Access to Age-appropriate, Medically Accurate Information**

Case managers shall provide foster youth with access to age-appropriate, medically accurate information about reproductive and sexual health care including unplanned pregnancy prevention, pregnancy testing, prenatal care, abstinence, use of birth control or protection, and abortion as well as the prevention, diagnosis and treatment of STIs. Case managers may provide this information to youth in many different ways. Information may be provided through county materials from their public health department, referrals to local health clinics such as Planned Parenthood, sharing online resources with the youth, ensuring youth receive access to comprehensive sexual health education provided through their school, offering youth attendance to conferences or trainings about safe sex and pregnancy prevention, or counties may choose to include this subject in their Independent Living Program curriculum. The list of medically accurate online resources, the list at the end of this document can be referenced and given to foster youth.

As a result of the recent passage of SB 89 for youth in foster care 10 years of age and older, case managers are required review the case plan annually and update as needed, to indicate that the case management worker has verified that the youth received comprehensive sexual health education once in junior high and once in high school, per Welfare and Institutions Code section 16501.1(a). The SB 89 also requires the case plan to be updated annually to indicate the case manager has informed the youth of his or her right to access age-appropriate, medically accurate information about reproductive and sexual health care.

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<sup>3</sup> See ACIN I-40-16 for further information

### C. Inform Foster Youth of Their Rights to Consent to Sexual and Reproductive Health Care

Case managers shall inform and explain to foster youth that they have the right to make their own decisions regarding sexual and reproductive health care. Case managers should be aware that foster youth can consent to reproductive and sexual health care at any age with the exception of services related to STIs (see consent ages identified below). Case managers are required to explain to foster youth that they do not need permission from a parent, caregiver, social worker or any other adult to obtain the following medical care:

1. Birth control or protection, pregnancy testing, and prenatal care, at any age,
2. Abortion, at any age,
3. Health care because of a rape or sexual assault, at any age,
4. Health care to prevent STIs and HIV, at age 12 or older, and
5. Testing and treatment for STIs and HIV, at age 12 or older.

Per SB 89, the case plan must be updated yearly to verify the case manager has informed the youth of the right to consent to sexual and reproductive health services, and his or her confidentiality rights regarding those services.

### D. Inform Foster Youth of Their Rights to Confidentiality and Written Consent Prior to Any Disclosure(s)

Case managers shall inform and explain to foster youth that they have the right to confidentiality regarding the reproductive and sexual health care services they receive. It is required that case managers explain to foster youth that if the youth receives reproductive and sexual health care services and/or asks a health provider any questions about sex, contraception or any other related topic during an appointment, the health care provider cannot share with the youth's parents, caregivers, group home, social worker, or probation officer without the youth's written consent. Case managers should also inform foster youth that they may ask their doctor, before they get a medical related service, if the doctor will maintain confidentiality and ask the youth for their written consent prior to any potential release of information.

Unless abuse, sexual abuse or exploitation is alleged or suspected, case managers should not disclose any confidential information regarding a youth's reproductive health, such as the youth's birth control method, the youth being sexually active, the youth's pregnancy, or decision to terminate a pregnancy, without the written consent of the youth. Before receiving reproductive or sexual health information, case managers should explain to youth that the information they share will remain confidential unless they consent to disclosure or there is a potential safety issue. County agencies may benefit by creating a form for tracking who the youth consents to having this information and when consent was given.

If a youth has not authorized disclosure of his/her private reproductive health information and the case manager must disclose pursuant to mandated reporter laws, the case manager should inform

the youth that they will be disclosing the information, and explain the reasons for disclosing, prior to doing so. The case manager may also consult with County Counsel.

#### E. Ensure Youth Are Up-To-Date On Their Annual Medical Appointments

Case managers shall ensure that foster youth receive a timely medical exam every 12-months based on the [Child Health and Disability Prevention \(CHDP\) Bright Futures Schedule for Health Assessments](#). For detailed information on this practice please refer to ACL [17-22](#). The Manual of Policies and Procedures section 31-405.24 states case managers shall ensure that children, youth and NMDs in foster care receive medical care which places attention on preventive health services through the Child Health and Disability Prevention (CHDP) Program, or equivalent preventive health services in accordance with CHDP Program's schedule for periodic health assessment.

#### F. Ensure Barriers to Services Are Addressed in a Timely and Effective Manner

Case managers are required to ask foster youth if they are facing any barriers in accessing reproductive and sexual health care services or treatment. The case manager may initiate these conversations with youth during regularly scheduled monthly contacts with the youth and when informing youth of their personal rights, which must be done at least once every six months. If the case manager learns that the youth is facing barriers in accessing services or treatment, the case manager shall ensure these barriers are addressed in a timely and effective manner. Some examples of typical barriers the youth may face are the youth is unaware of their insurance information or doesn't have a copy of his/her medical card, the youth being unaware of how to schedule a doctor's appointment, the youth not having transportation to a medical appointment. For further information about addressing these barriers, please read the "Sample Case Scenarios" document attached to this guide.

#### G. Ensure Personal Biases and/or Religious Beliefs Are Not Imposed Upon Foster Youth

The case manager shall not impose their personal biases and/or religious beliefs upon the foster youth. Case managers should put their personal feelings and values aside when talking with foster youth about sexual health and shall not sway, force, judge, or coerce foster youth. Showing respect and professionalism is very important in developing and maintaining a level of trust and openness with the foster youth. Because trust is important in all types of relationships, it is important the case manager asks the youth if they feel more comfortable talking to someone else such as a doctor, nurse, dependency court judge or counselor about a situation or issue they may be facing.

While ensuring that personal biases and beliefs are not imposed on youth, case managers should work with youth in a way that is culturally inclusive and trauma informed. A youth's cultural background and any history of trauma can greatly affect how a youth views their own sexuality and thinks about reproductive health matters.



Since the passage of the Continuum of Care Reform Act, [Assembly Bill 403 in 2015](#), there has been an emphasis that services to youth and families in child welfare need to be trauma informed and culturally relevant.

According to the [National Child Traumatic Stress Network \(NCTSN\)](#), “a trauma informed child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers.” Trauma informed services and systems “infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.”

Resources for working with youth in a trauma-informed, culturally competent way (including working with Lesbian, Gay, Bisexual, Transitioning, and Questioning (LGBTQ) youth) are provided in the “[ONLINE RESOURCES](#)” section of this document. These resources can be referenced and given to foster youth, their families, and caregivers.

## **RECOMMENDED DUTIES OF THE CASE MANAGER**

Recommended duties and responsibilities are defined for case managers in section III, items H-K, in [“California’s Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents.”](#) The following section of this guide will expand upon these recommendations and provide practical guidance to assist case managers with understanding this work.

### **H. Have Open and Honest Conversations with Foster Youth**

Open and honest communication is a critical ingredient of any relationship and helps build trust and rapport between the youth and case manager. Case managers need to be having open and honest conversations with foster youth younger than age 12 about puberty, body image, healthy relationships and sexual/reproductive health topics at a developmentally and emotionally appropriate level. Case managers should recognize this topic can be sensitive and/or uncomfortable. Case managers should remember to assess and be considerate of the youth’s feelings, and ask if they have a particular person that they trust and feel comfortable speaking with. Children and youth need a lot of guidance and information about healthy relationships, sex, the risks of STIs, and other related topics, even if they don’t appear to be interested. Therefore, the case manager needs to ensure foster youth have a designated person they feel comfortable to speak to. Building rapport with youth is a skill that requires the absence of judgment, an establishment of trust and assuming nothing. Be sensitive to youth’s development and needs to help foster a trusting relationship.

### **I. Include Reproductive and Sexual Health Education as a Case Management Service Objective**

The case manager should include reproductive and sexual health education as a Case Management Service Objective for foster youth age 10 years-old and older as well as NMDs. Reproductive and sexual health education should always be provided at a developmentally and emotionally appropriate level. Case managers should engage in age appropriate conversations with foster youth regarding reproductive health and confer with the youth’s school to see what topics have been, or will be, discussed in their comprehensive sexual health and Human Immunodeficiency Virus (HIV) prevention curriculum. By understanding what a youth is learning in their sexual health and HIV prevention curriculum, case managers can communicate with youth and help youth develop future goals to help minimize their chances of experiencing an unintended pregnancy or other sexual consequences.

### **J. Document in a Manner to Ensure the Foster Youth’s Privacy**

The case manager should document foster youth reproductive and sexual health care services information in a sensitive manner to ensure privacy and compliance with federal and state confidentiality laws. Case managers should have conversations with foster youth about sharing or discussing their personal and confidential information with others to ensure that their information is safe and handled with care and respect.

The ACL 16-32 shares instructions with case managers for entering information about a pregnancy on the Child Welfare Services/Case Management System (CWS/CMS). Following these instructions will avoid this private information becoming a part of the youth’s Health and Education Summary,

which frequently gets disseminated via court reports and placement paperwork to many adults in the youth's life. For additional information on documenting pregnancy information in a sensitive manner on CWS/CMS, please refer to ACL [16-32](#).

#### K. Provide Foster Youth with Information to Make Medical Appointments

The case manager should provide foster youth with information about how to make doctor appointments, including a list of medical provider options and the youth's medical insurance information. As a resource, case managers can download copies of the *Foster Youth Sexual and Reproductive Health Rights* brochure at <http://cdss.ca.gov/inforesources/Foster-Care/Healthy-Sexual-Development-Project> located in the Youth and Young Adults resource section. This brochure is designed specifically for foster youth and contains various topics of suggested questions to ask, such as a section entitled "**Questions to Ask Your Doctor.**"

## **TIPS FOR TALKING WITH YOUTH**

Speaking to youth and young adults about sex is not always a comfortable topic however, effective communication skills and building rapport are critical. Be understanding and develop a bond with the youth. Be authentic and non-judgmental when speaking, youth can tell when adults are genuine and will be more receptive to those they trust. The following tips can be used to build rapport and maintain a level of trust with youth or young adult and help ease the awkwardness or difficulty that is felt when having serious discussions.

- Be polite, smile and have a friendly disposition.
- Follow through with what you tell the youth or young adult.
- Be non-judgmental; stay away from stereotypes and preconceived ideas, for example:
  - Do not assume a youth's knowledge about sex, birth control, etc.
  - Do not assume a youth will be embarrassed if you talk to them about sex.
  - Do not assume the sexual orientation of a youth as being gay, lesbian, heterosexual, bisexual, asexual, etc. It is the youth's choice to decide what orientation best describes them.
  - Do not assume that based on a youths risky or sexual behaviors, you shouldn't continue to talk to them about making informed choices about their sexual health. Consistent communication is key.
- Use active listening. Be mindful to provide a young person a space to talk.
- Summarize the youth's feedback directly with the youth and ask them if you understand them correctly.
- Avoid criticism, regardless of your perspectives or personal feelings; youth have the right to make their own choices or decisions as it relates to their sexual and reproductive health and medical care.
- Remember, as a case manager, you are not required to be an expert and know all the answers. What is important, however, is that you are an "askable adult" working as a bridge for a young person knowing where to direct a youth or NMD to medically accurate, developmentally appropriate information.

## **Conclusion**

Assisting foster youth with their reproductive and sexual health may seem daunting, but is so important for these youth and their futures as they transition into adulthood. If you have concerns about fulfilling the responsibilities and duties described in this document, we recommend you speak with your management or support team at your county agency.

If there are questions regarding the policies described in this document, you may also contact the Placement Support and Services Unit at (916) 657-1858 or by email, at [SexualDevWorkgroup@dss.ca.gov](mailto:SexualDevWorkgroup@dss.ca.gov).

## CASE SCENARIOS

The following case scenarios illustrate some of the possible situations case managers may face in assisting foster youth with their reproductive health. Also included are the legal responsibilities of the case manager and some best practice suggestions for how a case manager should respond to the youth's needs or request.

### 1. Scenario:

Jill is a sixteen year-old foster youth. She lets her case manager know that she had unprotected sex recently and now she has missed her period and thinks she might be pregnant.

#### **What is the Case Manager required to do?**

The case manager must remind Jill of her personal rights, including the right to consent to pregnancy related care, which includes contraception, abortion and prenatal care. The case manager shall ask the youth if she needs any assistance with scheduling an appointment for pregnancy testing and if the youth needs assistance with transportation to any necessary medical appointments.

#### **What are some best practices for the case manager in this scenario?**

The case manager should approach this situation with sensitivity and concern for the youth. An unintended pregnancy can be a stressful and terrifying experience. The case manager should ensure that the youth's needs are met without letting their own personal biases affect their treatment of the youth's situation.

In addition to the immediate needs of scheduling the appointment and arranging transportation, the case manager should ask the youth what other kinds of support she needs. Is it ok for the case manager to talk to others involved with Jill's case about Jill's possible pregnancy, such as Jill's foster parents, her Court Appointed Special Advocate (CASA), attorney and/or birth parents? The case manager could create a document listing who is and is not allowed to know of Jill's condition and review this list with Jill to ensure Jill agrees.

The case manager should also provide and share local resources available to the youth such as any available support groups for pregnant youth (if needed), health clinics that provide reproductive health care services, and ways to access free contraception. The case manager should also follow up with the youth after the youth sees the doctor and determine what other needs the youth may have.

### 2. Scenario:

Inez is a thirteen year-old youth in foster care. During a regularly scheduled monthly visit, Inez tells her case manager and foster mom that she would like to talk to her doctor about birth control options but she isn't sure what documents or information she needs to visit the doctor.

#### **What is the Case Manager required to do?**

The case manager and foster mother should collaborate to ensure that any barriers to Inez accessing reproductive health care are addressed. The case manager must ensure that Inez

and her foster mother have Inez's medical insurance information, including insurance card, doctor's contact information and that Inez knows how to make an appointment with her doctor.

**What are some best practices for the case manager in this scenario?**

The case manager can let the youth know that she can ask her doctor important questions about her health and birth control options. Additionally, the case manager can share the "Know Your Sexual and Reproductive Healthcare Rights" brochure with Inez, which can be downloaded along with other tools, from [CDSS'](#) webpage for the Healthy Sexual Development Project. This youth-friendly brochure lists additional questions that youth may want to ask their doctor or healthcare professional about sexual and reproductive health.

The case manager should also inquire of the youth's well-being. Is Inez already sexually active and is she protecting herself from STIs and pregnancy? Is she in a safe and healthy relationship, free of abuse, coercion and violence? The case manager can also provide the youth with online materials and resources about healthy relationships and birth control methods available to her. Some of these resources may be found on CDSS' webpage for the [Healthy Sexual Development Project](#).

**3. Scenario:**

James, a fifteen year-old foster youth, shares with his case manager that he wants to go to the doctor to be examined for an STI, but the only appointments available are during school hours. He tells his case manager that he is embarrassed and doesn't want to tell his foster parent why he is seeing the doctor. He is unsure how to be excused from class without a note from his foster parent. He asks the case manager if he should just skip school so that he can see the doctor.

**What is the Case Manager required to do?**

The case manager shall ensure that any barriers James is experiencing in accessing reproductive and sexual health care services and treatment are addressed. The case manager can inform James that his school district may excuse him to attend a confidential medical appointment without a note from his foster parent or guardian<sup>4</sup>. James will need to speak with his school to inquire what he needs to do in order for him to miss school to attend a confidential medical appointment and have his absence excused. The school may allow James to sign himself out of school to attend the appointment but may require James to provide a doctor's note or verification of the visit in order to reenter school.

**What are some best practices for the case manager in this scenario?**

The case manager should follow up with James in a reasonable time to ensure that he was able to set up the appointment and get the information he needed from his school about getting his absence excused. If the school will not excuse James' absence, the case manager may need to sign James out of school and take him to the appointment.

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<sup>4</sup> Please see Education Code section 46010.1

Additionally, the case manager should ask James why he does not feel comfortable telling his foster parent about his medical appointment. The case manager should assess whether James is in a safe, supportive foster placement that meets his needs.

#### **4. Scenario:**

Carmen, a county social worker, finds that her personal beliefs are conflicting with her roles and responsibilities as a social worker. Carmen believes that homosexuality is a sin and is working with Staci, a fourteen year-old youth who identifies as lesbian. Staci frequently asks Carmen questions about safe sex and relationships which make Carmen feel very uncomfortable.

##### **What is the Case Manager required to do?**

Case managers are required to see that a youth's personal rights are upheld. One of these rights is that the case manager provides the youth access to information about reproductive and sexual health care, which may include conversations about birth control, sex and relationships. If a case manager cannot perform the requirements of their job without their personal beliefs and biases interfering, then they may not be suited to this work. If a case manager is not comfortable answering certain questions of the youth or providing the youth with access to services, then the case manager needs to respond to the youth's questions in a respectful manner and tell the youth that they will ensure that another trusted adult, for example a caregiver, CASA, the youth's physician, or therapist, assists them. The case manager should also tell their supervisor of this situation and how it was handled. The case manager should then follow up with the other trusted adult in a reasonable timeframe, to ensure the adult provided the youth with the information or service needed.

##### **What are some best practices for the case manager in this scenario?**

It is the case manager's responsibility to talk to foster youth about such important topics as sex, pregnancy prevention, and the risk of STIs. Case managers should receive initial and ongoing training regarding working with foster youth and the subject of reproductive and sexual health care issues. Training should cover looking at one's own biases and beliefs and recognizing how these may be in conflict with the requirements of working with foster youth. Additionally, case managers should speak to their supervisors and coworkers about fulfilling their responsibilities as case managers in spite of conflicting biases or personal beliefs. Training and supervision provided to case managers should reiterate the importance of professionalism and being able to set aside one's own biases.

#### **5. Scenario:**

Abraham, an eighteen year-old NMD, has a lot of questions about dating, sex and birth control methods for his social worker, Mark. Mark does not always know the correct or appropriate answers to Abraham's questions and it makes him nervous or anxious. Mark feels he has to know how to respond to all of Abraham's questions immediately.

##### **What is the Case Manager required to do?**

The case manager is not expected to automatically know the answers to all questions that a youth may have. Depending on the youth's questions or needs, there may be some situations where gathering the answers should happen very quickly, like when the youth is in crisis and

experiencing an unwanted pregnancy, when the youth needs treatment for an STI or when a youth is in a dangerous, unhealthy relationship. However, it is ok to not have all the answers on the spot. The case manager in this scenario can let Abraham know that he will look into his concerns and provide him with the appropriate resources that address his questions regarding dating, sex and birth control.

**What are some best practices for the case manager in this scenario?**

Case managers are advised to take a breath before answering a youth's questions, to use active listening and rephrase the youth's questions back to them, to ensure the case manager understands what the youth is asking. The case manager should then be clear with the youth and honest about what they do not know. Case managers should let youth know that they will research their questions and concerns and get back to them with the answers, or explore with the youth to find the answers.

Additionally, making time to speak with a supervisor to staff the case and speaking with other staff may assist the case manager with working with youth who have lots of questions. Case managers should also familiarize themselves with county resources and online resources to provide youth with questions regarding sexual and reproductive health issues.

**6. Scenario:**

Katrice, a fourteen year-old in foster care, asks her social worker how she can get free condoms as she is sexually active but does not want to get pregnant. Her social worker provides Katrice with information about a local health clinic that provides free condoms, no questions asked. Katrice visits the health clinic and gets condoms and later her foster mother finds the condoms. The foster mother demanded to know how Katrice got the condoms, and Katrice tells her that the social worker assisted her. The foster mother is now angry and tells the social worker that she is going to file a complaint with the county agency.

**What is the Case Manager required to do?**

The case manager should inform the foster parent of the youth's right to have access to confidential reproductive health care services, including contraception. Case managers will not have disciplinary action taken against them for doing their job and fostering the youth's rights. It is the case manager's duty to provide the youth with age appropriate medically accurate information and resources about reproductive health care, unplanned pregnancy prevention, abstinence, use of birth control, abortion and the prevention and treatment of STIs.

**What are some best practices for the case manager in this scenario?**

The case manager can provide the foster mother with a copy of ACL [16-82](#), which outlines the sexual health and reproductive rights of foster youth as well as provide a copy of this same ACL to the foster parent's Foster Family Agency if applicable.

The case manager should also have a conversation with the foster parent about what her fears are in regards to Katrice having condoms. Does the foster parent have concerns about Katrice's health or safety? Are there other resources or referrals the foster parent may need in order to support Katrice?



**7. Scenario:**

Ryva, a fifteen year-old male-to-female transitioning youth, wants to receive hormone replacement therapy to more closely align her secondary sexual characteristics with her gender identity. Ryva has asked the case manager if she needs permission or if she is old enough to consent to taking this medication or if her foster parent can sign consent.

**What is the Case Manager required to do?**

The case manager must inform Ryva that neither she nor her foster parent can legally consent to this type of medical service. The case manager must inform the caregiver and Ryva that in order to receive hormone therapy services, Ryva will need consent from either a biological parent, her medical rights holder or through a court order. The case manager should encourage Ryva to reach out to her attorney.

**What are some best practices for the case manager in this scenario?**

The case manager should ask Ryva what other types of support she needs. The case manager can assist Ryva with getting consent approved by a required party. The LGBTQ youth enter the foster care system for the same reasons as non-LGBTQ youth in care, such as abuse, neglect, and parental substance abuse. However, many LGBTQ youth have the added layer of trauma that comes with being rejected or mistreated because of their sexual orientation, gender identity or gender expression. The case manager should assess if Ryva needs referrals or assistance, as many LGBTQ youth are at risk for emotional and mental health issues and may experience homelessness or participate in such at risk behaviors as substance abuse and or risky sexual activity.

**8. Scenario:**

Theresa, a sixteen-year old foster youth, has shared with her foster parent that she is pregnant and wants to terminate her pregnancy. Theresa has scheduled an appointment for an abortion and asked her caregiver to drive her. The caregiver shares with Theresa's social worker she is not comfortable with taking Theresa to an appointment for an abortion. Theresa's social worker feels it is the caregiver's responsibility to transport Theresa to the appointment. .

**What is the Case Manager required to do?**

The case manager should remind the caregiver of the requirement for her to provide Theresa transportation to medical appointments, which includes appointments for reproductive and sexual health related services. If the caregiver continues to refuse to take Theresa to the appointment, the case manager must transport the youth or elect another trusted adult to transport the youth to the appointment. An appointment for an abortion is time-sensitive, therefore it is important that the case manager ensure that someone, whether it be the caregiver, case manager or another trusted adult, transports Theresa to this appointment promptly. The case manager can also provide the caregiver with a copy of [ACL 16-82](#), which outlines the youth's right to be provided transportation and other reproductive health rights.

**What are some best practices for the case manager in this scenario?**

The case manager could ask Theresa who she would like to transport and accompany her to the appointment. An appointment for an abortion can be an emotional experience for a youth. The youth should be supported through this experience with the person the youth feels most comfortable with, if at all possible.

The case manager may also find it helpful to engage the foster parent in a discussion using Safety Organized Practice methods, by asking the caregiver “what are we worried about” in regards to transporting Theresa to the appointment. Exploring the caregiver’s concerns will help the case manager fully understand the issue at hand from the caregiver’s perspective. By doing so, the case manager may be able to provide additional information to the caregiver which would alleviate some of the caregiver’s concerns.

## **ONLINE RESOURCES**

### **1. For Youth, NMDs, Caregivers, Social Workers and Probation Officers**

Information regarding birth control:

<https://thenationalcampaign.org/resource/pocket-protector-guide-birth-control-options>

<http://www.plannedparenthood.org/learn/birth-control>

To find a health center near you:

<https://www.plannedparenthood.org/health-center>

<http://www.cfhc.org/programs-and-services/clinic-map>

Family Planning, Access, Care, and Treatment Program:

[www.familypact.org](http://www.familypact.org)

Information and services for LGBTQ youth, their family and caregivers:

<https://lgbtcenter.org>

<http://saccenter.org>

<http://www.cssp.org/reform/child-welfare/get-real/what-we-do/publications>

### **2. Resources for Youth and NMDs**

Youth friendly websites about birth control, safe sex and healthy relationships:

<http://stayteen.org/>

<http://www.teensource.org/>

<http://bedsider.org/>

Resources for LGBTQ+ Youth:

<https://lgbtcenter.org>

<http://saccenter.org>

<http://www.cssp.org/reform/child-welfare/get-real/what-we-do/publications>

<http://www.cdc.gov/lgbthealth/youth-resources.htm>

### **3. Resources for Caregivers**

Tips and resources for caregivers about talking to youth about sex and sexuality:

<https://www.plannedparenthood.org/parents/talking-to-kids-about-sex-and-sexuality>

List of resources for caregivers about talking to youth of different ages about sex:

<http://www.plannedparenthood.org/parents/resources-for-parents>

#### 4. Resources for Case Managers

Tips and information about talking to youth about pregnancy prevention and other topics:

[www.TalkWithYourKids.org](http://www.TalkWithYourKids.org)

<https://www.healthychildren.org/English/ages-stages/teen/dating-sex/Pages/default.aspx>

<http://www.etr.org>

<http://www.positivepreventionplus.com/>

<http://www.cdc.gov/lgbthealth/youth-resources.htm>

<http://thenationalcampaign.org/resource/briefly-its-your-responsibility-talk-youth-pregnancy-prevention-youth-foster-care>

Delivering Culturally Inclusive/Culturally Competent Services:

<https://www.childwelfare.gov/topics/systemwide/cultural/services/>

<https://www.gradschools.com/masters/social-work/msw-cultural-competence>

San Diego County Behavioral Health Services Handbook on cultural competence:

<http://www.sandiegocounty.gov/hhsa/programs/bhs/documents/CulturalCompetenceHandbook11-1-11.pdf>

This resource provides information about talking to youth about SOGIE: Sexual Orientation, Gender Identity and Gender Expression:

[http://www.cfyetf.org/education-summit\\_17\\_2361847496.pdf](http://www.cfyetf.org/education-summit_17_2361847496.pdf)

#### 5. Available Training and Research:

The Prevalence of Foster Youth and Pregnancy (9 minute video):

<http://thenationalcampaign.org/resource/crucial-connection>

The Education, Training and Research website provides health education materials in sexual health, pregnancy prevention, LGBTQ+ wellness, dating violence and more:

<http://www.etr.org/>

Positive Prevention Plus lessons (in compliance with the California Healthy Youth Act). Lessons include: Sexual Health (for grades 7-12), Preventing Unplanned Pregnancies and HIV/AIDS:

<http://www.positivepreventionplus.com/>

The Family & Youth Service Bureau's National Clearinghouse on Families and Youth offers a training website for courses in "Creating a safe space for LGBTQ teens" and "Adolescent Development:"

<http://www.acf.hhs.gov/programs/fysb/resource/online-app-training>

The California Department of Education's Comprehensive Sexual Health Education and HIV/AIDS Prevention Education:

<http://www.cde.ca.gov/ls/he/se/>

The U.S. Department of Health and Human Services' Office of Adolescent Health offers evidence-based interventions on teen pregnancy prevention programs:

<http://www.cdc.gov/HealthyYouth/index.htm>

The California Family Health Council's Learning Exchange is a resource for health professionals to learn and share best practices in reproductive and sexual health care service delivery:

<http://www.cfhc.org/learning-exchange>

The National Child Traumatic Stress Network provides information about trauma informed services, treatments for trauma, and how different populations are impacted by trauma.

<http://www.nctsn.org/resources/topics/creating-trauma-informed-systems>

# Help Me to Succeed

A GUIDE FOR SUPPORTING YOUTH  
IN FOSTER CARE TO PREVENT  
TEEN PREGNANCY



GEORGIA CAMPAIGN FOR  
ADOLESCENT POWER & POTENTIAL  
Education • Prevention • Action  
For Adolescent Health



**The National Campaign**  
to Prevent Teen and Unplanned Pregnancy

## Introduction

The National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign) and the Georgia Campaign for Adolescent Power & Potential (GCAPP) are mission-driven organizations that seek to improve the lives and future prospects of children and families by preventing early pregnancy and parenthood among youth. Teen pregnancy is closely linked to a number of critical social issues, including poverty and income disparities, health, education, child welfare, and overall child well-being. Children born to teen mothers are more likely to be victims of child abuse and neglect and to be in the child welfare system. The National Campaign and GCAPP have worked to identify ways to support youth in care prevent teen pregnancy and to reach their goals by delaying starting a family until they're ready. It is our hope that this report will serve as a resource for case workers, foster parents, and other individuals in the child welfare sector to help youth in care avoid unplanned pregnancy and parenthood.

Youth in foster care, in particular, are at a significant risk of teen pregnancy. For instance, a teen girl in foster care is 2.5 times more likely to become pregnant by age 19 than her adolescent peers not in foster care. Also, approximately half of 21-year-old males transitioning out of foster care reported getting a partner pregnant compared to 19 percent of their non-foster care peers.<sup>1</sup> While adolescents in the general population are at risk for pregnancy, youth in foster care often face additional circumstances out of their control that can leave them even more vulnerable to pregnancy. For some time now, The National Campaign and GCAPP have worked to understand what youth currently in care and those transitioning out of care want and need from those around them to help them avoid early pregnancy. Both organizations have done this by working with youth in foster care themselves and providing these young people with the chance to articulate their thoughts and opinions.

GCAPP commissioned Messages of Empowerment (TEAM-MOE) to work with youth in care in Georgia after recognizing a need to include

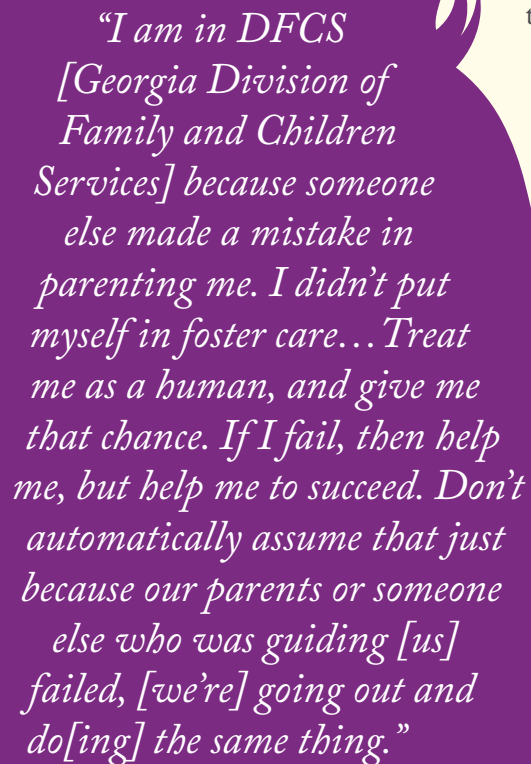
the youths' voice in the work of the organization. In 2010, TEAM-MOE began using the "FAST" Model (Frame the Issue, Ask the Right Questions, Select the Right Data Sources, Think About Solutions) to train current and former youth in foster care to interview their peers about teen pregnancy and prevention. Thirty-nine youth in care were interviewed for this project; the average age of participants was 17.5 years. The young people discussed their feelings about being in foster care, teen pregnancy, sex education, the role adults play in their lives—particularly when it comes to discussing sexuality and reproductive health—and what supports and services they thought would help them make healthy decisions about sex and pregnancy prevention. While this project specifically represents the voices of youth in foster care living in Georgia, the opinions and findings mirror what The National Campaign has found among youth in care nationwide.

This report combines messages directly from youth in foster care in Georgia with national research to provide insight and advice to adults working in the child welfare sector. Understanding a youth's feelings and opinions regarding the risks of early pregnancy and prevention strategies can help child welfare professionals provide more effective support for the young people they support in foster care. Below are suggestions on how to find the balance between helping youth in care have a "normal" adolescent experience while providing them with the support they need to overcome barriers they face as a result of being in the child welfare system.



## What is life like for youth in foster care in the United States?

Adolescence is a period of transition and development often marked by risky behavior. When supported appropriately, many young people learn from their experiences and successfully navigate the often difficult and confusing path to adulthood. Teens in foster care too often find themselves at a disadvantage compared to their peers who are not in care, because their life experiences make establishing consistent supportive relationships extremely difficult.



*“I am in DFCS [Georgia Division of Family and Children Services] because someone else made a mistake in parenting me. I didn’t put myself in foster care... Treat me as a human, and give me that chance. If I fail, then help me, but help me to succeed. Don’t automatically assume that just because our parents or someone else who was guiding [us] failed, [we’re] going out and do[ing] the same thing.”*


Youth are placed in foster care because child protective services and the court system have determined their home is no longer a safe environment for them. These situations are identified based on apparent maltreatment including neglect and physical, sexual, or emotional abuse. Upon entering the child welfare system, youth may face additional upheaval by being separated from siblings or moving between multiple placements such as group homes, residential facilities, kinship care, and non-relative foster homes. Out of approximately 400,000 youth in foster care in the United States,<sup>ii</sup> about 33 percent are teens between 13-18 years old.<sup>iii</sup> Older youth entering foster care in particular tend to remain in the system longer than

those who are placed when they are younger. They are also *less* likely to be adopted or achieve permanency before turning 18 compared to their younger peers in care.<sup>iv</sup> Not having an adoptive family or permanency plan in place before transitioning out of care puts older youth in care at an increased risk for negative outcomes including homelessness, unemployment, poverty, incarceration, and pregnancy at a young age.<sup>v</sup>

### FINDINGS ON YOUTH IN CARE IN THE U.S.

- Eighty percent of youth who transition out of care without an adoption plan entered foster care at age 10 or older.
- In 2009, youth age 18-21 who transitioned out of care had spent an average of 7.5 years in the system.
- Over half of youth who transition out of care experienced at least one episode of homelessness.
- One in four youth who transition out of care will be incarcerated within the first two years after they leave the system.<sup>vi</sup>

For many youth, out-of-home care can be traumatic due to the instability of multiple, short-term placements; lack of emotional connection with caregivers or staff; and, in some cases, abuse within these places of care. It is difficult to safely seek support or develop trusting relationships in situations where trauma has been or is present. Youth in care are also more likely to have already experienced poverty, homelessness, and



*“Me and my friends don’t talk about ‘foster youth’ being sexually active. Other kids are sexually active [too].”*



## What do youth in foster care think about the risks of teen pregnancy?

During interviews, youth in care identified several factors that put them at risk for early pregnancy. These factors, which echo findings from previous work with youth in care around the country, include: (1) low self-esteem as a result of the stigma youth often face for being in foster care; (2) a lack of guidance, making it easier to succumb to peer pressure; (3) lack of consistent relationships with trusting adults; (4) a history of abuse and neglect; (5) lack of opportunity during adolescence to experience “normal” and “healthy” intimate and social relationships; (6) wanting someone to love; and (7) concern about birth control.

### STIGMA OF BEING IN FOSTER CARE

Being in foster care can inherently create dependency. This is largely due to young people’s minimal control over the decisions being made about their personal lives, including where they will attend school, their type of placement, and changing placements. On average youth can have four to five placements throughout their time in the foster care system, making it a challenge to form long term social relationships which can, in turn, be motivation for getting pregnant. As one youth notes, *“There’s a real need on their part to have a longer-term relationship, and they see a baby as a way to achieve that...thinking that having a baby with their boyfriend will cement that relationship as well.”* Intimate sexual relationships might satisfy important needs that would otherwise be met within the family relationship,

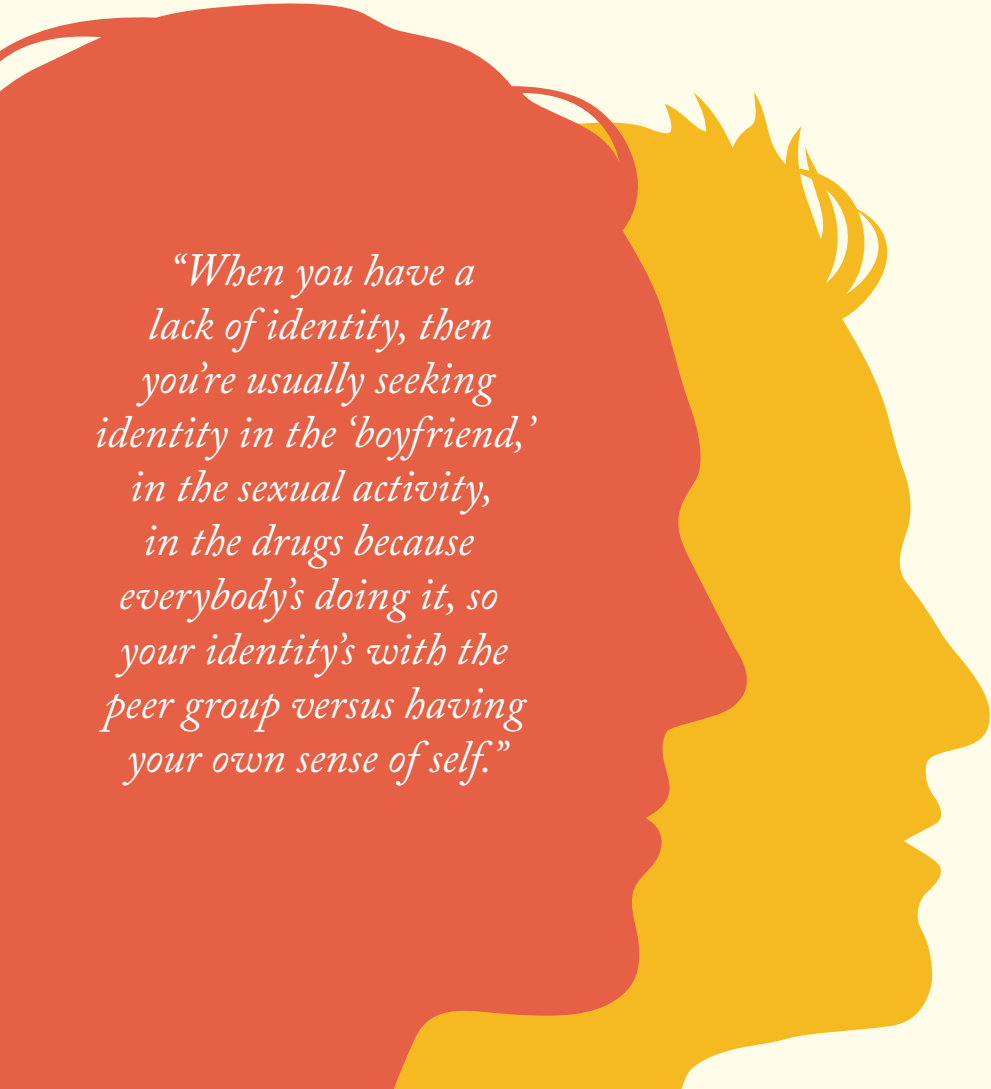
*“With teen pregnancy it’s not about you anymore, it’s about the child. Most of us ain’t with the father so you got to think about what if he gets tired and he doesn’t want the baby. He can leave. You can’t go anywhere.”*

instability, all of which have been linked to teen pregnancy. Consequently, many youth in care spend much of their time navigating the system in survival mode and looking to peers for support. As one youth respondent noted, *“You have to look out for yourself more when you’re in DFCS.”*

Although data provide a comparative view of the risk of early pregnancy faced by youth in care with their non-foster care peers, some youth in care expressed that using this information broadly and without context can unintentionally make them feel singled-out, or characterized as “hypersexual” compared to their peers. When youth in foster care in Georgia were asked to talk about teen pregnancy, several of the respondents felt frustrated and reiterated that, *“it’s not just about foster kids getting pregnant.”* They felt a more important message was to stress that *all* teens are at risk of becoming pregnant or causing a pregnancy if they’re sexually active and that not all youth in care are necessarily sexually active. Respondents also shared several structural and social aspects of the child welfare system they believe led to increased risky behavior and unintended pregnancies among youth in care.



including emotional support, safety, trust, and love. Another youth said, *“Foster kids get bullied more than other kids on the street.”* The stigma of being in foster care may also subject teens more bullying and peer pressure. Similar to all adolescents, youth in care want to fit in with their peers. Also similar to youth more broadly, this desire to be accepted may lead teens in care to having unprotected sex or using drugs.



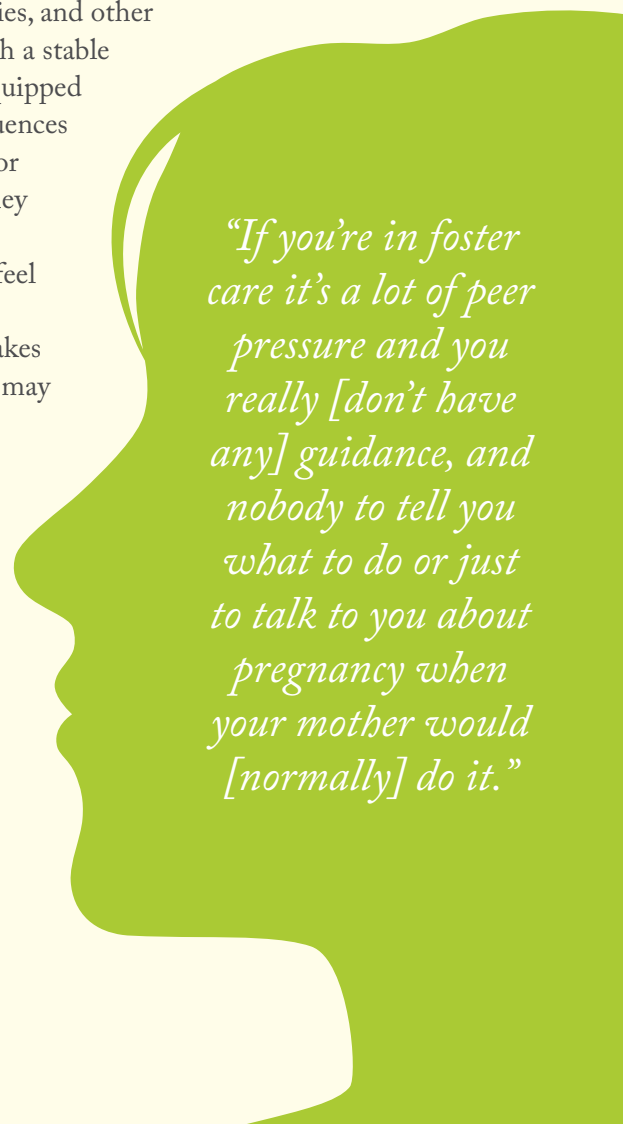
*“When you have a lack of identity, then you’re usually seeking identity in the ‘boyfriend,’ in the sexual activity, in the drugs because everybody’s doing it, so your identity’s with the peer group versus having your own sense of self.”*

## **FACING PEER PRESSURE WITH LITTLE GUIDANCE**

Youth identified the lack of guidance while being in care, particularly as it relates to pregnancy prevention, as a factor that makes it more difficult to resist pressure to engage in risky behavior. Peer pressure is a normal aspect of teenage development. Teens who successfully navigate this pressure often do so with the help of a strong support network including parents, families, and other community influences. Teens with a stable family structure may be better equipped to resist the pressure of peer influences due to a desire to please parents or other mentors whose approval they care about.<sup>viii</sup> Youth in care often lack strong support networks or feel like there are no adults who care about their well-being, which makes it difficult to resist activities that may have negative consequences.

## **LACK OF CONSISTENT RELATIONSHIPS WITH TRUSTING ADULTS**

For most teenagers, adolescence is a time for experimentation and exploration. This is no different for teens in foster care. Teens in care often lack permanent mentors in their lives which can affect many of their decisions, including those about sex. Older youth in care, in particular, face



*“If you’re in foster care it’s a lot of peer pressure and you really [don’t have any] guidance, and nobody to tell you what to do or just to talk to you about pregnancy when your mother would [normally] do it.”*

multiple disadvantages when it comes to building consistent relationships with trusting adults, partly due to the average length of time they spend in the system and their number of placements. The strength of a relationship with a caring adult plays a pivotal role in helping youth in foster care avoid pregnancy and sexually transmitted infections (STIs).<sup>ix</sup> This relationship can be with a relative, a social worker, or any responsible caring adult; the most important factors are that the relationship is consistent and built upon mutual trust.<sup>x</sup> This might be particularly challenging for youth if they don't feel welcomed or supported by the child welfare system or their caregivers. As one youth notes, *"DFCS acts like we asked them to be in foster care. If I could go home, I would. I don't want anybody taking care of me and they're making it seem like such a big deal that they're doing this and that but I didn't ask them for anything."*

Other youth express challenges in developing positive relationships in both group homes and in-home placements. One youth mentioned that, *"... group homes aren't so warm and fuzzy because the relationships aren't there."* Another said about foster families, *"A lot of parents that do fostering don't really get to know the child like they should. I've been moved from home to home. I never really had a stable home."* Two more youth specifically stated that, *"...not having anyone to listen to how our daily life is going..."* and *"...living with adults who don't understand where we are coming from..."* are factors they believe contribute indirectly to sexual risk-taking. What is clear from the majority of these youth is the absence of a trusting adult they can turn to for advice and support.

*"We deal with staff members who don't seem to care."*

## HISTORIES OF ABUSE AND NEGLECT

Teens in foster care cited abuse and neglect as factors that may place young people at higher risk of teen pregnancy. When asked about who might be at risk for getting pregnant at a young age, one youth mentioned, *"...young females that have been molested or raped, or in some kind of category where someone has sexually harassed them or abused them at some point in their lives."* Experiences with physical and sexual abuse are common among youth in care. Young adults who lived in foster care were nearly two times more likely to have experienced forced sex compared to all other youth.<sup>xi</sup>

## LACK OF OPPORTUNITY FOR "NORMAL" RELATIONSHIPS

While individual placements vary depending on the situation, in general there are a multitude of rules and restrictions young people face upon entering the child welfare system. Youth interviewed mentioned several times that the restrictions they face make it hard for them to have "normal" teenage experiences and connect with their peers. According to one youth, shielding them from the world *"...makes a young girl*

*"This is like a lock down facility and it's not supposed to be. This is a foster youth group home not a DJJ [Department of Juvenile Justice] group. It shouldn't be a lock down facility. It should be open where you can go to sporting events, have fun, and feel like a real teenager."*

*rebellious and that makes them go out there and do way worse things than just have sex.”* The ability to experience relationships during adolescence has a direct impact on the development of positive self-esteem that youth carry into adulthood. For youth in care, this opportunity is often stifled. Strong, positive peer relationships have proven to be helpful to youth overcoming challenges associated with turbulent family situations which would particularly benefit youth in care.<sup>xiii</sup> Allowing youth the opportunity to engage in positive peer relationships, while providing them with the support and skills they need to navigate risky situations, is critical to healthy adolescent development.

#### WANTING SOMEONE TO LOVE

The idea of having a baby as a teenager is not always viewed negatively among youth in care. Several young people suggested that teens in care are actually motivated to get pregnant and have a baby as a means of receiving unconditional love. One youth said, *“Some young females actually want babies. It’s not an accident because they feel like they want somebody that’s going to love them. They don’t have nobody.”* This urge for unconditional love was also expressed in focus groups among youth in care across the country.<sup>xiiii</sup>

Making the decision to start a family can be a common response to the instability and lack of control youth grow accustomed to while in care. They want to succeed at having a family in a way that their parents did not.

*“While you’re in the system they try to put all of these rules and restraints on you. But, at the end of the day, when you get out there, you’re gonna do what you want to do.”*

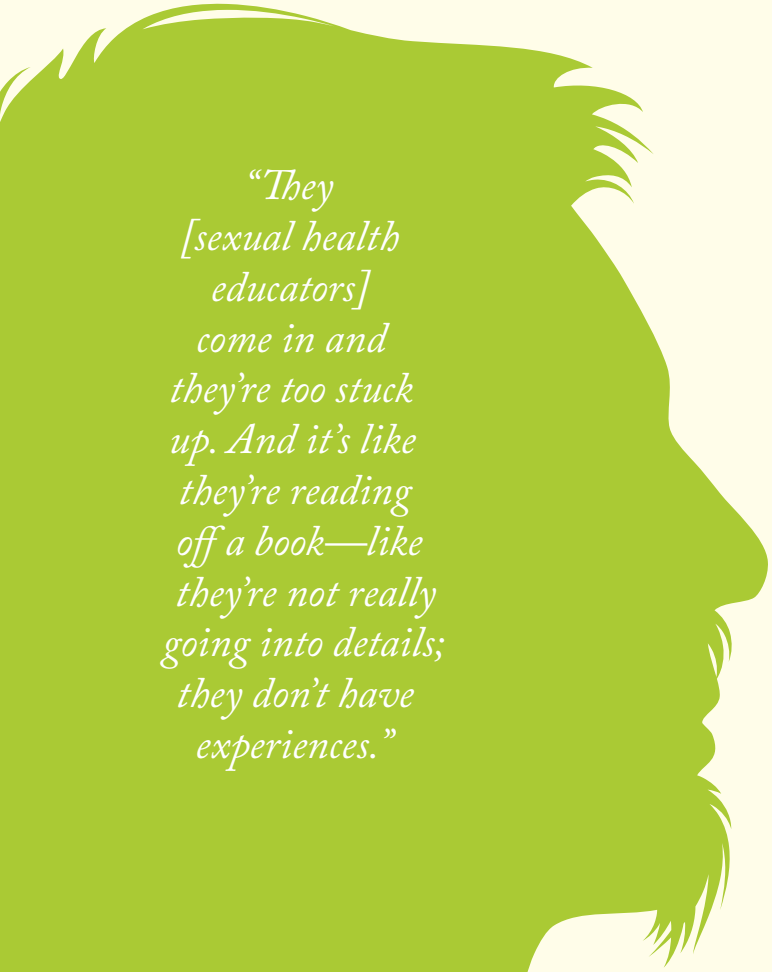
Some youth also believe that having a baby with their boyfriend will cement the relationship and provide some continuity in their life. Even though youth interviewed acknowledged that this belief frequently does not work, pregnancy and giving birth as a single mother is still not always seen as a detriment to their future, especially if the girl is *“...strong and they’ve got it together.”*

#### CONCERN ABOUT BIRTH CONTROL


Like youth in the general population, youth in care may not have received much reliable or accurate information regarding birth control. Some teens refuse to use certain birth control methods—hormonal methods, in particular—out of concern about possible side effects. However, rejecting hormonal birth control, including some of the most effective and long acting methods, puts youth in care at risk of unintended pregnancy. Young people’s attitudes about birth control reveal a need for more education about how methods work, the myths and misunderstandings about side effects, and the risk of pregnancy with each method. Educating youth on the importance of condom use is also

*“I have enjoyed the joy that I bring to my child and the joy that he brings to me. It’s like waking up in the morning and sometimes you might not be able to get out of the bed, or you might be discouraged, or you feel that you’re down and out, but you see your child and it just motivates you to keep going.”*


critical to helping them prevent pregnancies as well as STIs. When asked about condom use, several youth responded saying, *“Most of my friends don’t like condoms…”* or *“It doesn’t feel right.”* One girl said about her boyfriend: *“He feels like they suck... birth control sucks too.”*



*“They [sexual health educators] come in and they’re too stuck up. And it’s like they’re reading off a book—like they’re not really going into details; they don’t have experiences.”*



*“I don’t feel that either one [condoms or birth control] are important to use.”*



*“I don’t want to use birth control. I don’t like taking medicine and I don’t want to take something that’s gonna change my hormones, like changing my period.”*

## What's Missing?

The youth interviewed provided valuable insight into the risks that youth in care face in regards to teen pregnancy as well as gaps in child welfare structures and supports. In addition to more support in general, youth in care could benefit from stronger resources and better information on topics related to pregnancy planning, prevention, and safer sex.

### **FOSTER PARENTS NEED TO BE APPROACHABLE AND PREPARED TO DISCUSS SEXUAL HEALTH AND SEXUALITY WITH THEIR YOUTH.**

When asked about discussing sex and related topics with their foster parents, youth gave both positive and negative responses. It is clear that establishing relationships with their foster parents can be difficult for a variety of reasons, and discussing issues related to sexual health might be particularly fraught given the sensitive nature of the topic. Several youth mentioned the fear of being judged by their foster parents and other adults and how that can deter them from broaching these subjects. One youth said they would feel more comfortable talking about sex with their foster parent, "...if they wouldn't judge me or think of me differently." Another youth simply said, "I need to know they care." And another stated, "I need to have this conversation with a person who is not going to be jumping down my throat all the time." Previous negative experiences with foster parents can add to the hesitance of approaching them about these subjects. One youth said, "I've had so many foster parents in my life. I had several that were just scary—just too scared to talk to [them] about it."

*"Listen to us first, then educate us later."*

Foster parents can play a critical role in supporting youth to make safe and healthy decisions. They are in a position to facilitate these discussions if they are given the right tools and knowledge to offer advice and guidance to their youth. While some youth interviewed said they would never feel comfortable talking with their foster parents, others said that if the parent could "be honest and open" and "down to earth" then it would be easier. It is possible for foster parents and the youth they care for to establish two-way, healthy relationships and it can be extremely positive for both when that alliance is created.<sup>xiv</sup>

### **SEX EDUCATION OFFERED TO YOUTH IN CARE NEEDS TO BE RELEVANT TO THEIR LIVES.**

Despite the lack of evidence-based teen pregnancy prevention programs specifically developed for youth in care, many of the youth interviewed

*"It would be easier for me to have a conversation if they came to me."*

*"Me, personally, I had a good foster parent. She was my best friend. I feel that I could talk to her about anything. I've been with her for seven years. I've been with her since I had my baby. She was down and upset but she got to a point where she got over it. And so [she just said], 'Don't do it anymore.'"*

had previous experience with some type of sex education. In general, their feelings toward sex education were apathetic, *“We sit there and we listen even to the statistic... it’s like, I heard what you said but I don’t care.”* According to one of the youth interviewed, *“It’s not effective because after a certain amount of time you just block out everything.”* Again, youth identified the fear of being judged as a factor that inhibited them from participating in these programs. One young person said, *“As soon as you go to a pregnancy prevention class, they automatically assume that you’re having sex.”* One youth suggested that sex education should be mandatory or court-ordered to avoid being judged or seen as promiscuous for participating.

*“Most [health educators] do and say the same things you heard at the last meeting. So what’s the point in going if you already know what they’re gonna say?”*

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. This can be done through examples and facilitated discussions as opposed to a lecture-style class.<sup>xv</sup> In other words, *“Make the sessions more conversational than informational.”* They also mentioned including conversations providing moral guidance in sex education programs such as, *“Good or bad, we want to know when is the right time to lose your virginity.”* This would be particularly helpful for youth who lack

relationships with trusted, adult mentors. The class could provide them some insight and skills when faced with decisions like having sex.

### **YOUTH IN CARE NEED ACCESS AND ENCOURAGEMENT TO VISIT HEALTH CLINICS FOR SERVICES.**

Like all youth, youth in care need to be able to access health services, including reproductive health services. As one teen mentioned, *“Access can be contingent on the ability or the willingness of the adult to do that.”* Others also mentioned that in more suburban or rural settings access can be particularly challenging. Youth in care are also worried about being judged if they access sexual health services. As one youth stated, *“Some will not use the clinic because they have trust issues.”*

*“We are tired of hearing ‘don’t do this or you’ll get an STD’ or ‘you’ll get pregnant.’”*

*“Looking at my situation now, I feel like I needed stronger birth control because it just wasn’t worth it to me.”*

## What now? How will you move forward to better support youth in care?

When working with youth in care, it is critical to be sensitive to their need to be considered a “normal” teen and have “normal” teenage experiences while taking into account increased risks they may face as a result of being in care. Finding the balance between these two concepts is difficult, but not impossible:

### **ADDRESS TEEN PREGNANCY AS SOMETHING THAT CAN HAPPEN TO ANY TEEN.**

Youth in care have said they don't like being singled out or labeled, they simply want programs that deliver medically accurate and reliable information.

### **PROVIDE OR IDENTIFY TRAININGS FOR PRIMARY CAREGIVERS.**

Medical providers should be familiar with the risk factors associated with being in care. In particular, providers should be able to refer young people to necessary mental health and reproductive health services and be prepared to handle issues of abuse, common among youth in care.

### **PROVIDE TRAINING FOR ADULTS WHO WORK WITH YOUTH IN FOSTER CARE.**

Foster parents, social workers, and those who work directly with youth in care can benefit from professional development specific

to the topic of teen pregnancy prevention—starting with the basics, sex education 101. They need to be prepared to answer questions and refer young people to quality reproductive health resources.

### **OFFER EVIDENCE-BASED SEX EDUCATION ON A CONTINUOUS BASIS.**


Youth in care report a lack of accurate information about preventing pregnancy, contraception, and other topics. Consider the fit of a program when engaging this population—in particular take into consideration the length (number of sessions) of a program, age-appropriateness, literacy level of your materials, as well as whether the program takes trauma into account.

### **MAKE SEX EDUCATION AN ON-GOING COMPONENT OF EXISTING PROGRAMS WITHIN CHILD WELFARE AGENCIES.**

This will ensure that more youth will receive the knowledge required to make healthy decisions about sex, contraception, and related topics.

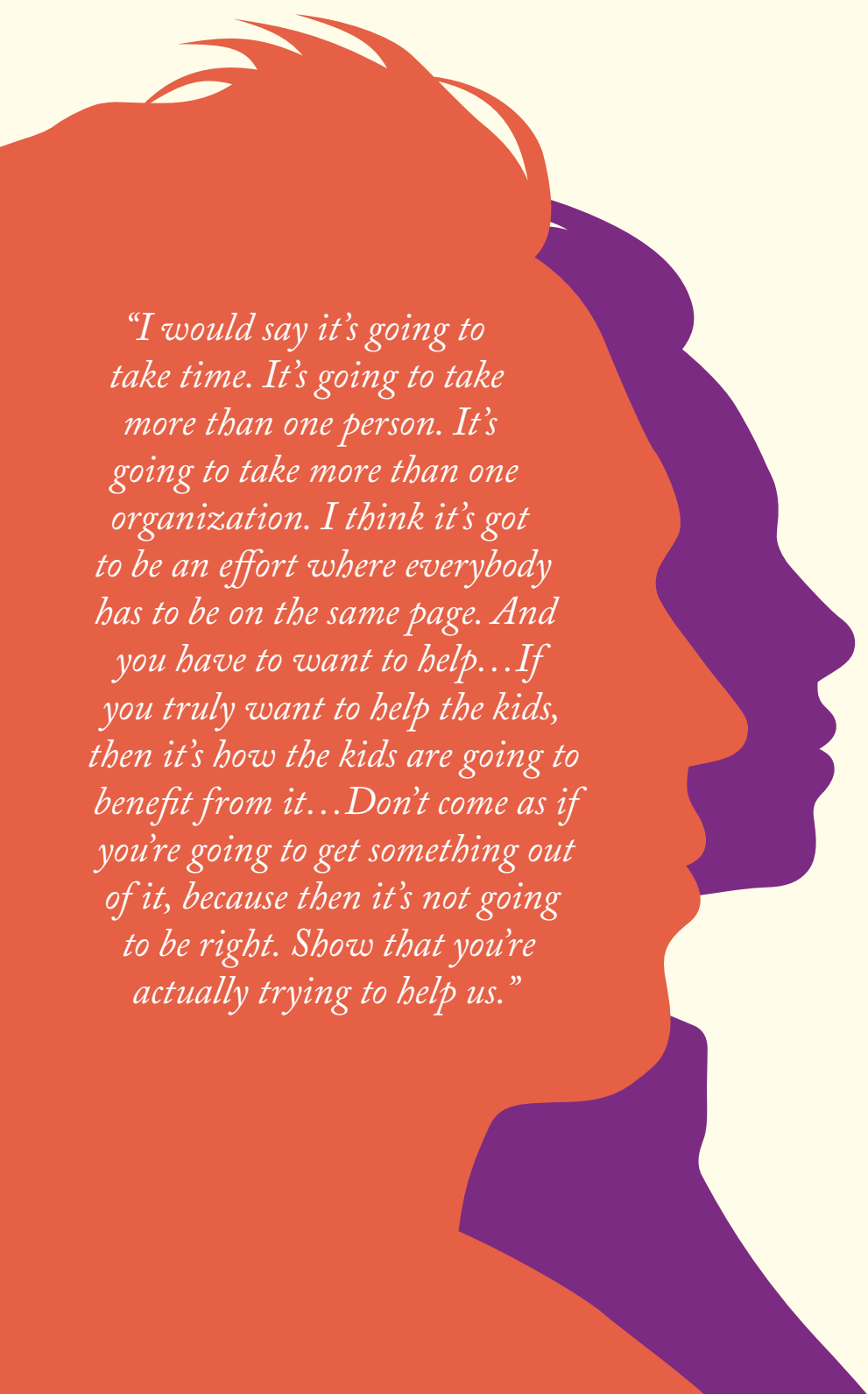
### **ENSURE YOUTH HAVE ACCESS TO AGE-APPROPRIATE RESOURCES AND SERVICES ON HEALTHY RELATIONSHIPS AND REPRODUCTIVE HEALTH.**

Youth in foster care are often transient so they need to be able to access quality reproductive health resources from wherever they are. Consider developing wallet cards, or distributing existing resources such as the *Pocket Protector: A Guide to Birth Control Options* (available through the Campaign's Online Store: <http://bit.ly/Zltdjm>), and recommend websites teens can access with a mobile phone or text messaging resources where they can get their questions answered in real time.



*“Give us a voice. And even if you don't give us a voice, advocate for us!”*





*“I would say it’s going to take time. It’s going to take more than one person. It’s going to take more than one organization. I think it’s got to be an effort where everybody has to be on the same page. And you have to want to help...If you truly want to help the kids, then it’s how the kids are going to benefit from it...Don’t come as if you’re going to get something out of it, because then it’s not going to be right. Show that you’re actually trying to help us.”*

## About this Publication

The National Campaign and GCAPP worked together on this report. Firsthand accounts from youth in foster care used in this publication were compiled by TEAM-MOE in collaboration with GCAPP between October 2010 and June 2011, before the federally funded Personal Responsibility Education Program (PREP) began in Georgia. The Georgia Department of Human Services (DHS) Division of Family and Children Services (DFCS) has since taken steps to incorporate these findings into their current PREP implementation with youth in the Georgia foster care system.

As a result of federal funding Georgia’s PREP initiative is (1) providing evidenced-based teen pregnancy prevention programming to youth in foster care; (2) providing science-based relationship education programming to youth in foster care; (3) providing training to adult caregivers (foster parents, group home staff, and case managers) who work with youth in foster care to increase their ability to discuss healthy decision-making about sexual health and interpersonal relationships; (4) including sexual health education and health services in foster youth’s written transitional living plans; and (5) ensuring that the sexual and reproductive health of foster youth are assessed as part of their regularly scheduled comprehensive health screenings.

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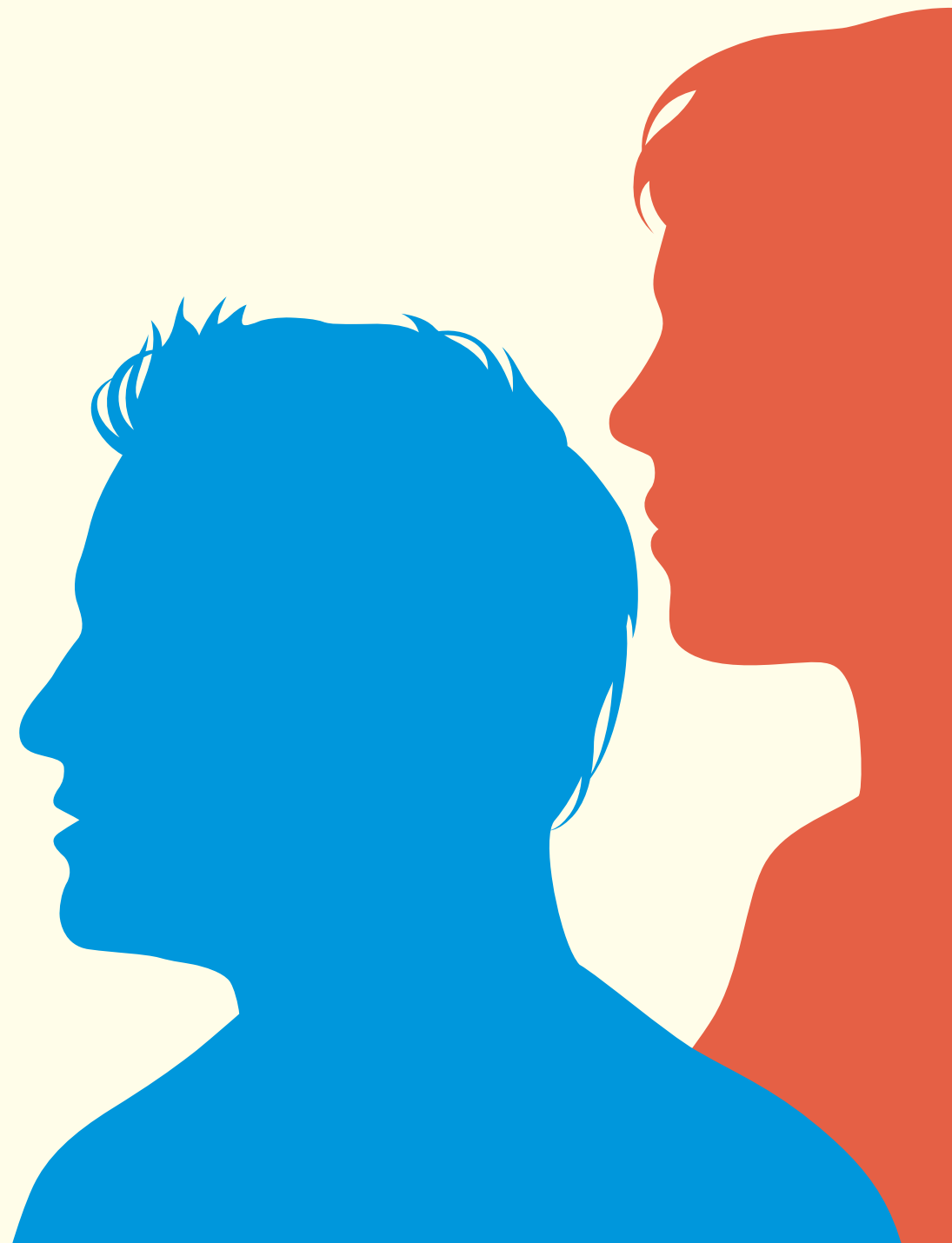
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# Your Sexual and Reproductive Health Care and Related Rights

**No judgements! You have the right to sexual health information that only includes medical facts and not anyone's opinions.**

Do you know your rights when it comes to your sexual and reproductive health? Even if you're under age 18, you have rights! Knowledge is power, so read your rights below:

1. You have the right to have your personal rights explained and provided to you in a manner that you understand.
  2. You have the right to get health care, including reproductive and sexual health care.
- Continue reading to learn more about what kind of reproductive and sexual health care services you can get.**
3. You have the right to make your own decision about the following kinds of care (meaning you can say "yes" or "no" and do not need permission from a parent, caregiver, social worker, or any other adult if you want this care):
    - a. Female or male birth control or protection, pregnancy testing, and prenatal (pregnancy) care, at any age,



- b. Abortion, at any age,
  - c. Health care you need because of a rape or sexual assault, at any age,
  - d. Health care to prevent sexually transmitted infections (STIs) and HIV, at age 12 or older, and
  - e. Testing and treatment for STIs and HIV, at age 12 years or older.
4. You have the right to get the information you want about sexual health care. You can ask your doctor or another trusted adult about:
    - a. Reproductive and sexual health care,
    - b. Ways to prevent pregnancy and pregnancy testing,
    - c. Abortion,
    - d. Prenatal (pregnancy) care, like monthly or weekly doctor visits during pregnancy, and
    - e. How to prevent and treat STIs, including HIV medication and the Human Papillomavirus (HPV) vaccination.
  5. When you get sexual or reproductive health care, or ask your doctor questions about sex, your doctor cannot share that information with your parents, caregivers, group home, social worker, or probation officer without your written consent. There are a few small exceptions.
  6. You have the right to ask your doctor to explain "privacy" to you and who can and cannot get your medical information before you get any health care.
  7. You have the right to choose your own health care provider for sexual and reproductive health care, as long as the provider is covered by your Medi-Cal or other approved insurance.
  8. Your caregiver, group home, or social worker must help you with transportation to get reproductive and sexual health care services in a timely manner.
  9. You have the right to get, have, and use the birth control or protection of your choice in your placement, including:
    - a. Condoms, including the female condom
    - b. Diaphragm
    - c. Birth control patch, pill, or shot
    - d. Spermicide
    - e. Dental dam
    - f. Emergency contraception (morning after pill)
    - g. Medications to prevent STIs
  10. You have the right to keep your personal items, like birth control, in your own private storage space. Condoms or other protection, or birth control cannot be taken away from you as a punishment or due to your caregiver's religious beliefs or personal feelings. You have the right to be free from unreasonable searches of your belongings.
  11. You have the right to fair and equal access to services, placement, care, treatment, and benefits. You have the right to not be treated unfairly, harassed, or discriminated against because of your sex, sexual orientation, gender identity, HIV status, or other factors like race, religion, ethnic group identification, ancestry, national origin, color, or mental or physical disability.
  12. You have the right to contact and make complaints about violations of your rights to state agencies, including the Community Care Licensing Division of the California Department of Social Services and the state Foster Care Ombudsperson (**See the "Resources" section of this brochure for more information**).
- Complaints are confidential and you cannot be threatened or punished for making complaints.

# KNOW your RIGHTS

**Helpful Tip: If you feel like someone violated your rights, or you need support making a complaint, call the Office of the Ombudsperson toll-free at**

**1-877-846-1602**

# Know Your Sexual and Reproductive Health Rights

# KNOW your RIGHTS

# Foster Youth Sexual and Reproductive Health Care Rights



## TALKING TO OTHERS ABOUT SEX AND YOUR RIGHTS: SUGGESTED QUESTIONS TO ASK

Whether you're abstinent (not having any sex), thinking about having sex, or already sexually active, it's important and okay to talk about sex and relationships with a trusted adult. Your trusted adult may be a *doctor, social worker, mentor, attorney, judge, teacher, family member or someone else you feel comfortable talking to*. It is also important and okay to talk about these things with a romantic partner. But how do you know what to say or how to start a conversation? It is not always easy, so here are some suggested questions to start the conversation:

### QUESTIONS TO ASK YOUR PARTNER

- » Will you respect my decision about sex, and about what I'm okay doing and not doing? How do you feel about my decision?
- » How are we going to make sure we protect ourselves against STIs?
- » Have you ever tested positive for an STI? If so, were you treated?
- » Are you having sex with other people?

- » Have you thought about your future goals? How do you feel about an unplanned pregnancy?

### QUESTIONS TO ASK YOUR DOCTOR

#### About your rights...

- » I know I have a right to privacy in sexual and reproductive health care. What does that mean in this office? Are you always going to ask for my written permission before you share any of my information?

#### About birth control or protection...

- » How do I know what birth control method is right for me? What are the common side effects of the different birth control methods?
- » Will my caregiver or parent find out if I decide to use a birth control? Can they pressure me to use a certain kind of birth control?
- » Do I need to use birth control or condoms if I'm transgender or dating someone of the same gender as me?
- » How do you use a condom correctly?
- » What is emergency contraception and how can I get it?

#### About STIs...

- » I had sex without a condom. Should I get tested for an STI and/or pregnancy?
- » What do I need to know about STIs, including testing, treatment, and prevention?

### QUESTIONS TO ASK A TRUSTED ADULT

#### About relationships...

- » What does a healthy relationship look like? How can I show my partner I love them?
- » Is jealousy a sign of love?
- » I'm being hurt or threatened by my partner. What can I do?
- » I feel like my partner is pressuring me to have sex or do things I am not ready for or feel uncomfortable with. What should I do?

- » How do I know when I'm ready to have sex with someone?

### About sexuality and gender identity...

- » How does someone know they are lesbian, gay, bisexual, transgender, or questioning?
- » If I have a same sex crush, does this mean I'm gay or lesbian?
- » Can I sleep in a room or use the restroom based on the gender I identify with?
- » Is touching myself wrong? Is it okay if I'm in a private place such as my bedroom or bathroom?

### About going to visit the doctor...

- » How do I make an appointment to visit the doctor? Are doctor appointments confidential between me and my doctor?
- » What information and documents will I need when I visit the doctor?
- » I need information about local community resources and public transportation to visit the doctor. Where can I get this information?

### About pregnancy or birth control...

- » I need information about birth control. Where can I get this information?
- » Does someone have the right to take away my birth control or condoms?
- » Can someone force me to go on birth control?
- » I think I might be pregnant. Where can I get information about pregnancy testing, prenatal care (if I need it) and/or the different options that are available?

### RESOURCES:

**California Office of the Foster Care Ombudsperson** – To file a complaint regarding your foster youth rights contact the Ombudsperson at 1-877-846-1602 or email [www.fosteryouthhelp.ca.gov](http://www.fosteryouthhelp.ca.gov)

**California Department of Social Services, Community Care Licensing** - To file a complaint against a state licensed group home or foster home call 1-844-538-8766

**[www.genderspectrum.org/](http://www.genderspectrum.org/)** - Information and resources about gender sensitive topics

**[www.glaad.org/transgender/resource](http://www.glaad.org/transgender/resource)** Information and resources for transgender people

**[www.loveisrespect.org](http://www.loveisrespect.org)** – Information about sex, healthy relationships, dating, dating abuse, and sexting

**[www.plannedparenthood.org/learn/birth-control/](http://www.plannedparenthood.org/learn/birth-control/)** - Information about birth control

**[www.bedsider.org/methods](http://www.bedsider.org/methods)** - Information about birth control

**[www.safehelpline.org](http://www.safehelpline.org)** - National Sexual Assault Hotline 1-800-656-HOPE (4673)

**[www.stayteen.org](http://www.stayteen.org)** – Information about relationships, love, sex, and pregnancy

**[www.teenhealthrights.org](http://www.teenhealthrights.org)** – Youth friendly guide to sexual health rights

**[www.teensource.org/condoms/free](http://www.teensource.org/condoms/free)** - Sign-up for free condoms if you are 12-19 years old and live in California



The suggested resources in this brochure are provided for your convenience for general informational purposes only. The California Department of Social Services bears no responsibility for accuracy, legality, or content of these external websites.



## **Foster Care Case Management Workers: 12 Required Duties & Responsibilities\***

*\*Applies to both Social Workers and Probation Officers*

### **Case Workers Shall Provide...**

1. Youth and NMDs with a copy of the Foster Youth Rights upon entry into foster care and at least once every six months at the time of scheduled contact.<sup>1</sup>
2. Youth and NMDs with access to age-appropriate, medically accurate information about reproductive and sexual health care, unplanned pregnancy prevention, abstinence, use of birth control, abortion and the prevention and treatment of STIs.<sup>2</sup>

### **Case Workers Shall Inform...**

3. Youth, in an age appropriate manner, of their rights to consent at any age to pregnancy-related care, including contraception, abortion, and prenatal care.<sup>3</sup>
4. Youth, in an age appropriate manner, of their right to consent at age 12 or older to the prevention, diagnosis and treatment of STIs.<sup>4</sup>
5. Youth and NMDs about their confidentiality rights regarding medical services and seek the youth's and NMD's written consent prior to any disclosure of their sexual or reproductive health information.<sup>5</sup>
  - a. The case management worker (social worker or probation officer) shall also inform youth and NMDs of their right to withhold consent to such disclosure(s).

### **Case Workers Shall Ensure:**

6. Youth are up-to-date on their annual medical appointments.<sup>6</sup>
7. The case management worker (social worker or probation officer), in collaboration with the foster care provider, shall ask the youth and NMD if they are facing any barriers in accessing reproductive and sexual health care services or treatment, and shall ensure any barriers are addressed in a timely manner.<sup>7</sup>
8. Youth receive comprehensive sexual health education that complies with state standards at least once in middle school and at least once in high school.<sup>8</sup>

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<sup>1</sup> WIC section 16501.1(g)(4).

<sup>2</sup> WIC sections 16001.9(a)(27) and 369(h) authorizes the social worker to provide access to this information prior to age 12, even though the age for minor consent for STI treatment is age 12.

<sup>3</sup> WIC sections 369(h), 16001.9(a)(27), 16501.1(g)(4); Family Code sections 6925, 6926. The right to consent to abortion at any age was established by the California Supreme Court in *American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307 (1997).

<sup>4</sup> See footnote 3, above. NMDs have the medical consent rights of other adults. WIC section 303(d).

<sup>5</sup> ACL 16-88.

<sup>6</sup> ACL 16-88.

<sup>7</sup> ACL 16-88.

<sup>8</sup> WIC section 16501.1(g)(20), (21).

### **Case Workers Shall Not Impose...**

9. The case management worker (social worker or probation officer) shall not impose their personal biases and/or religious beliefs upon the youth and NMD.<sup>9</sup>

### **Case Workers Shall Document in the Case Plan (for all youth and NMDs ages 10 and older) ...**<sup>10</sup>

10. For youth in middle or high school, that youth has received sexual health education at least once in middle school and at least once in high school or how the county will ensure the youth receives the education
11. That worker has informed the youth or young adult:
  - a. That he or she may access age-appropriate, medically accurate information about reproductive and sexual health care, including, but not limited to, unplanned pregnancy prevention, abstinence, use of birth control, abortion, and the prevention and treatment of sexually transmitted infections.
  - b. In an age- and developmentally appropriate manner, of his or her right to consent and confidentiality rights regarding those services.
  - c. How to access reproductive and sexual health care services.
12. That worker has facilitated access to that care, including by assisting with any identified barriers to care, as needed.

### **CDSS Recommends...**<sup>11</sup>

- The case management worker (social worker or probation officer) should include reproductive health education as a Case Management Service objective for youth 10- years-old and older, as well as NMDs, at a developmentally and emotionally appropriate level.
- The case management worker (social worker or probation officer) should engage in age-appropriate conversations with foster youth regarding reproductive health and confer with the youth's school to see what topics have been, or will be, discussed in their comprehensive sexual health and Human Immunodeficiency Virus (HIV) prevention curriculum.
- The case management worker (social worker or probation officer) should document the youth's and NMD's reproductive and sexual health care and services in a sensitive manner to ensure their privacy and compliance with federal and state confidentiality laws.<sup>12</sup>

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<sup>9</sup> ACL 16-88.

<sup>10</sup> WIC section 16501.1(g)(20), (21).

<sup>11</sup> ACL 16-88.

<sup>12</sup> See ACL 16-32 for guidelines on how to properly document sensitive medical information for youth in foster care.



## **TIP SHEET FOR PARENT ATTORNEYS ON UNPLANNED PREGNANCIES**

- Explain the new healthy sexual development and pregnancy prevention requirements in the case plan to your client.
- Explain that the social worker or probation officer must inform their child in an age appropriate manner of their rights every six months
- Explain that the social worker or probation officer must provide access to age appropriate, medically accurate information about sexual development, reproductive and sexual health care, prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and prevention and treatment of STI to their child.
- Explain to your client that if their child is 10 years of age and older, the social worker or probation officer is required to review the case plan annually and update as needed, to indicate that the case management worker has verified that the youth received comprehensive sexual health education once in junior high and once in high school.
- Explain to your client that their child has the right to confidentiality regarding the reproductive and sexual health care services they receive regardless of age. (Exceptions: the age of consent for health care to prevent, test, and treat STIs and HIV is 12 years of age or older)
- Ask your client if they have talked to their child about reproductive health
- Ask your client if their child has had any classes on reproductive health rights
- Ask your client if they have any cultural or religious beliefs around these issues that the social worker or probation officer should be aware of prior to speaking with the child.
- If your client has any questions, concerns, or objections, talk to the social worker or probation officer. If that does not work, ask to raise them in court. Depending on the circumstances, you may want to ask for an in chambers discussion or for the child to be excluded from the hearing for this specific purpose.

# Tips For Talking With Clients

## Ensuring Clients Know Their Rights

- Explain that the social worker/probation officer must inform them of their rights every 6 months in a way that they can understand.
  - Be familiar and ready to discuss those rights with your client
- Explain that the social worker/probation officer must give them information that they can understand about sexual development, reproductive and sexual health care, prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and prevention and treatment of STIs.
- Explain that they have the right to consent to or decline medical care (without need for consent from a parent, caregiver, guardian, social worker, probation officer or the court) for :
  - The prevention or treatment of pregnancy, including contraception, **at any age** (except sterilization)
  - An abortion, **at any age**
  - Diagnosis and treatment of sexual assault, **at any age**
  - The prevention, diagnosis, and treatment of STIs and HIV, **at age 12 or older**
- Explain that they have a right to confidentiality regarding the reproductive and sexual health care services that they receive.
- Ensure that there are no barriers to receiving reproductive and sexual health care services.

## Ensure Clients Have Someone to Talk To

- Assume no one else is talking to them about sexual health
- It's never too early to start a conversation about sex and relationships
- Have an open door for questions and conversation
- Provide helpful resources
- Don't impose your values
- Support planning for the future

## TIPS & TOOLS FOR TRUSTED ADULTS:

# Pre-Teen/Early Adolescent



A trusted adult should be someone a youth can speak with openly and honestly. Use the tips and guidelines below to start important conversations early, plan for the future, and build trust with pre-teens.

### Key Facts about this Age Group:

- They are experiencing the physical changes of puberty, perhaps more slowly or quickly than their peers (puberty starts anywhere from age 8-14, in general).
- They have a heightened interest in friends, cliques, and romantic partners.
- They are concrete thinkers.

### Assume No One Else Is Talking to Them About Sexual Health.

- Very few youth in foster care report that someone is talking to them about sex, love, and relationships.
- Talking to your teen about healthy relationships and sex is normal. You should be incorporating elements of these discussions into your conversations with pre-teens in order to facilitate an easier conversation in the years to come by normalizing it earlier.
- Review policies on sex education. It is important to assume that no one else is addressing these topics with the child, so why not you?

### It is Never Too Early to Start a Conversation About Sex and Relationships.

- The conversation can begin with topics like consent, puberty, and healthy vs unhealthy relationships.
- At this age, youth are increasingly concerned about what their peers think. It is important to ask about peers and other relationships early, normalizing the conversation as a foundation for more in years to come.

### Use Pop Culture to Start Talking.

- You could begin a conversation by incorporating music, movies, or TV shows that the youth enjoys. You might ask about friends, possible romantic relationships, or future romantic relationships
- **Script:** "I want to know more about who you spend time with because I care about you and I care about the things and people that are important to you. Most of all, I want to make sure that the people around you, support you, respect you, and appreciate you."

### You Don't Have to Be an Expert But You Should Be an Askable Adult.

- An askable adult may not know all the answers, but they are a trusted adult with an open door for questions and conversation. (*Remember: Youth who have disclosed past sexual trauma may be triggered by such discussions. In this case, it is best to ensure that the youth has access to a mental health professional and meet them where they are in order to facilitate appropriate conversations about sex and parenting.*)

**17%** of foster youth reported age at first intercourse between 10 and 12 years old.



Courtney, M. E., Okpych, N. J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., & Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Youth at Age 19*. Chicago, IL: Chapin Hall at the University of Chicago.



### **Know Where to Look for the Answers.**

- Check out [StayTeen.org](http://StayTeen.org) for games, media, Q&A, and educational materials for your youth.
- Try [LevelsRespect.org](http://LevelsRespect.org) for great resources on healthy relationships—consider doing the ‘Relationship Spectrum’ activity together to spark a conversation.

### **Put Yourself In Their Shoes!**

- Youth get much of their information on sex from peers and online sources that are not always reliable. Open the door for conversations so that you can correct misinformation and learn together if it’s a topic you are unfamiliar with.
- Youth learn about relationships from what they see. This can include biological parent or foster parent relationships, extended family, siblings, TV shows, and movies. Utilize conversations about positive relationships to navigate other influences the youth may experience.

### **Plan For The Future and Celebrate Success.**

- Whether it’s academic, extracurricular, or personal achievements, celebrate it! Motivation is a key tool in personal development and pregnancy prevention strategies. Communicate with other adults in the youth’s life to encourage activities that motivate the youth.
- Ask open ended questions and provide support:
  - “What do you want to be when you grow up? How can we make that dream a reality?”
  - “Do you want a family someday?”
  - “How do you want to be treated?”

### **Don’t Impose Your Values.**

- Young people—especially adolescents—are very sensitive to judgment and won’t be as open or confiding if they feel as though you are judging them. Try your best to leave your personal values at the door and know that being objective is in the best interest of the youth.

# Transition Aged Youth (13-17)

A trusted adult should be someone a youth can speak with openly and honestly. Use the tips and guidelines below to start important conversations early, plan for the future, and build trust with teens.

### Key Facts about this Age Group:

- They may have mood swings, and may be experiencing love or having sex with romantic partners.
- They are beginning to think abstractly but still have difficulty with decisionmaking and navigating tough situations.
- They are experimenting with different identities, both in physical ways and with different groups of friends, all while trying to distance themselves from their families.

### Assume No One Else Is Talking to Them about Sexual Health.

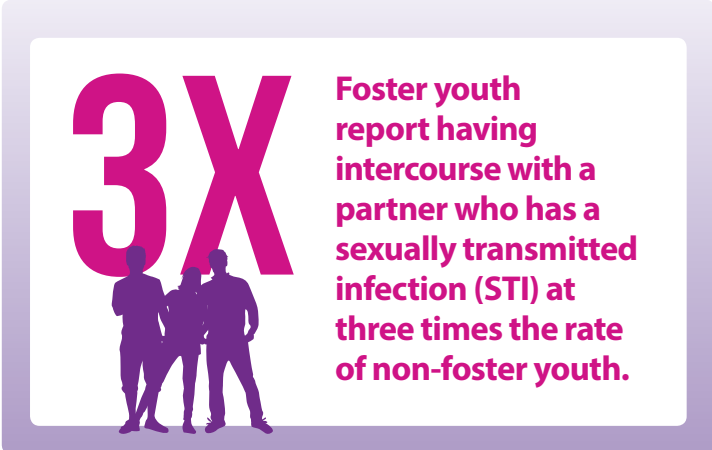
- Very few youth in foster care report that someone is talking to them about sex, love, and relationships.
- Talking to your teen about healthy relationships and sex is normal and should be incorporated into discussions about life and transition planning.
- Review policies on sex education. It is important to assume that no one else is addressing these topics with the child, so why not you?
- No state explicitly requires parental consent or notification for contraceptive services. However, two states (Texas and Utah) require parental consent for contraceptive services paid for with state funds. If you'd like more information, check your local policies.

### Let's Talk About Sex, Baby!

- While you might want to wait until they are mentally and emotionally ready to talk about sex, don't imply negativity or associate guilt with sex. Teens are sensitive to such connotations and this can influence their future relationships—it can also raise challenging questions for them about previous experiences. *(Remember: Teens who have disclosed past sexual trauma may be triggered by such discussions. In this case, it is best to ensure that the teen has access to a mental health professional and meet them where they are in order to facilitate appropriate conversations about sex and parenting.)*

### Fact vs Fiction.

- Teens get much of their information on sex from peers and online sources that are not always reliable. Open the door for conversations so that you can correct misinformation and learn together if it's a topic you are unfamiliar with.
- Youth learn about relationships from what they see. This can include biological parent or foster parent relationships, siblings, TV shows, and movies. Utilize conversations about positive relationships to navigate other influences the youth may experience.



**3X** Foster youth report having intercourse with a partner who has a sexually transmitted infection (STI) at three times the rate of non-foster youth.

Bilaver, L. A. & Courtney, M. E. (2006). *Science says #27 issue brief: Foster care youth*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy

- Medically accurate information about sexual and reproductive health is crucial to a teen's wellbeing. Talk to other adults in the youth's life and consider bringing this up in front of a judge or case worker who has the authority to mandate educational programs.

### Help Teens Recognize Unhealthy Patterns in Relationships.

- Many teens are unaware of how to recognize unhealthy behavior within a relationship. Ask about a teen's relationship and have a two-way conversation about positive/negative traits in a partner. Be aware that a significantly older partner, or the appearance of gifts/clothes/money without explanation, could be a sign of commercial sex exploitation or human trafficking. *(Tip: Admit that it might be awkward at first to talk about these things, this recognition may help build trust and break the ice.)*
- **Script:** "I know that talking to me about your relationship with your partner maybe a bit awkward. But, let me be straightforward with you—I may not always have the answers and I am sure that when we talk about relationships that I will stumble and not say the right thing from time to time. Still, I promise you two things: (1) I am always here to listen and hope that you will come to me with any questions or concerns you might have, and (2) I will always do the absolute best I can to help you with the decisions you make."
- **Script:** "I am interested because I care about you and I care about the things and people that are important to you. If you are involved with someone, I want to help you make sure that person is someone with whom you are comfortable, someone who supports you, someone who respects your ideas and opinions, and someone who appreciates all the things that make you who you are."

### Get Informed to Provide Better Support.

- Check out [Bedsider.org](http://Bedsider.org) and consult a physician about which birth control options may be best for your teen. If the teen discloses a romantic relationship, consider asking if they have discussed birth control methods with their partner, if not, this could be the sign of an unhealthy relationship.

### Provide Helpful Resources

- Check out [StayTeen.org](http://StayTeen.org) for games, media, Q&A, and educational materials for your youth.
- Try [LovelsRespect.org](http://LovelsRespect.org) for great resources on healthy relationships, consider the doing the 'Relationship Spectrum' activity together to spark a conversation.

### Plan For the Future and Celebrate Success.

- Whether it's academic, extracurricular, or personal achievements, celebrate it! Motivation is a key tool in personal development

## ASK does your partner...



Courtney, M. E., Okpych, N. J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., & Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Youth at Age 19*. Chicago, IL: Chapin Hall at the University of Chicago.

and pregnancy prevention strategies. (Remember to discuss the benefits of foster care, such as monetary supplements for higher education opportunities.) Communicate with other adults in the youth's life to encourage activities that motivate the youth. Weave in conversations about future family formation to help empower them to determine when, if and under what circumstances to get pregnancy.

**Ask Open Ended Questions and Provide Support:**

- “What do you want to be when you grow up? How can we make that dream a reality?”
- “Do you want a family someday?”
- “How do you want to be treated by your friends, romantic partners, etc.?”

**Help Them Make Pregnancy and Childbearing More Concrete.**

- Ask questions specifically about how pregnancy and childbearing might impact their current situation. These conversations can emphasize that pregnancy can be planned and should be for the health of a parent and child.

**Be Inclusive.**

- It is at this time in a teen's life when they are trying to identify themselves. Whether your teen identifies as LGBTQ, a parent, or with another identity, be respectful of that and use inclusive language. (Remember: Having this conversation with males is equally important as females, young men should understand the personal, financial, and legal obligations of fatherhood.)

**Don't Impose Your Values.**

- Young people—especially adolescents—are very sensitive to judgment and won't be as open or confiding if they feel as though you are judging them. Try your best to leave your personal values at the door and know that being objective is in the best interest of the youth.

**ASK**  
potential questions...



## TIPS & TOOLS FOR TRUSTED ADULTS:

# Young Adult (18+)



A trusted adult should be someone a youth can speak with openly and honestly. Even if the youth decides to leave care at age 18, they might stay connected with you. Use the tips and guidelines below to start conversations, plan for the success, and create stability.

### Key Facts about this Age Group:

- They are capable of thinking abstractly and thinking about how their current actions will influence their futures, but they still need support in developing this skill.
- They are almost fully developed physically and much more mature emotionally than in previous stages.
- They are clarifying their own values and beliefs.

### Assume No One Else Is Talking to Them About Sexual Health.

- Very few youth in foster care report that someone is talking to them about sex, love, and relationships.
- Talking to your teen about healthy relationships and sex is normal and should be incorporated into discussions about life and transition planning.
- Review policies on sex education. It is important to assume that no one else is addressing these topics with the child, so why not you?
- No state explicitly requires parental consent or notification for contraceptive services. However, two states (Texas & Utah) require parental consent for contraceptive services paid for with state funds.

### Let's Talk About Sex, Baby!

- Sex isn't a bad thing. While it is fair to encourage your teen to wait until they are mentally and emotionally ready for sex, don't imply negativity or associate guilt with sex. Teens are sensitive to such connotations and this can influence their future relationships. *(Remember: Teens who have disclosed past sexual trauma may be triggered by such discussions. In this case, it is best to ensure that the teen has access to a mental health professional and meet them where they are in order to facilitate appropriate conversations about sex and parenting.)*
- De-stigmatize the discussion of sex, sexual and reproductive health, and contraception. By encouraging and engaging in candid, open conversations with your teen you can normalize the topic and build trust.

- Sex is an act that can create physical and emotional connections with other individuals. Sex, in the context of healthy behaviors and relationships, should be included in the discussion of health and life planning.

### Fact vs Fiction.

- Teens get much of their information on sex from peers and online sources that are not always reliable. Open the door for conversations so that you can correct misinformation and learn together if it's a topic you are unfamiliar with.

**2X**

**By age 19, youth in foster care were more than twice as likely as all youth to have given birth to a child.**

Pecora, P. J., Williams, J., Kessler, R. J., Downs, A. C., O'Brien, K., Hiripi, E., & Morello, S. (2003). *Assessing the effects of foster care: Early results from the Casey national alumni study*. Seattle, WA: Casey Family Programs



- Youth learn about relationships from what they see. This can include biological parent or foster parent relationships, siblings, TV shows, and movies. Utilize conversations about positive relationships to navigate other influences the youth may experience.
- Medically accurate information about sexual and reproductive health is crucial to a teen's wellbeing. Talk to other adults in the youth's life and consider bringing this up in front of a judge or case worker who has the authority to mandate educational programs.

### Help Teens Recognize Unhealthy Patterns in Relationships.

- Many teens are unaware of how to recognize unhealthy behaviors within a relationship. Ask about a teen's relationship and have a two-way conversation about positive/negative traits in a partner, friend, family member, or other adult. *(Tip: Admit that it might be awkward at first to talk about these things; this recognition may help build trust and break the ice.)*
- **Script:** "I know that talking to me about your relationship with your partner may be a bit awkward. But, let me be straightforward with you. I may not always have the answers and I am sure that when we talk about relationships that I will stumble and not say the right thing from time to time. Still, I promise you two things: (1) I am always here to listen and hope that you will come to me with any questions or concerns you might have, and (2) I will always do the absolute best I can to help you with the decisions you make."
- **Script:** "I am interested because I care about you and I care about the things and people that are important to you. If you are involved with someone, I want to help you make sure that person is someone with whom you are comfortable, someone who supports you, someone who respects your ideas and opinions, and someone who appreciates all the things that make you who you are."

### Support Condom Use.

- Young people in foster care are at great risk for sexually transmitted infections (STIs) and unintended pregnancy. Using condoms alongside other birth control methods is crucial for reducing this risk. Ensure that teens have access to condoms. *(Remember most health departments and family planning clinics offer free condoms.)* Consider taking your teen to buy condoms and discuss using condoms. *(Remember: Condoms should be used for oral, anal, and vaginal sex.)*
- **Script:** "I know talking about condoms can be awkward. I am bringing this up because I care about you. It's important to discuss condom use with your potential sexual partners. What do you know about condoms? If you bring up condoms and your partner refuses to wear one, this is a sign of controlling

## ASK does your partner...



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behavior and emotional manipulation. However, not all partners will readily accept condoms and that is why condom negotiation is so important. *(Remember: Teens should mention both STI and pregnancy prevention as benefits of condom use, if not, tell them!)*

### Know Your Options.

- Check out [Bedsider.org](http://Bedsider.org) and consult a physician about which birth control options may be best for your teen. If the teen discloses a romantic relationship, consider asking if they have discussed birth control methods with their partner. If not, this could be the sign of an unhealthy relationship.

### Provide Helpful Resources.

- Teens often admit that they are not sure where to find trustworthy information.
- Check out [Bedsider.org](http://Bedsider.org) for games, media, Q&A, and educational materials for your youth.
- Try [LovelsRespect.org](http://LovelsRespect.org) for great resources on healthy relationships—consider the doing the ‘Relationship Spectrum’ activity together to spark a conversation.

### Plan For the Future and Celebrate Success.

- Whether it’s academic, extracurricular, or personal achievements, celebrate it! Motivation is a key tool in personal development and pregnancy prevention strategies. *(Remember to discuss the benefits of foster care, such as monetary supplements for higher education opportunities.)* Communicate with other adults in the youth’s life to encourage activities that motivate the youth. Weave in conversations about future family formation to help empower them to determine when, if and under what circumstances to starting forming a family.
- Ask open ended questions and provide support:
  - “What do you want to be when you grow up? How can we make that dream a reality?”
  - “Do you want a family someday?”
  - “How do you want to be treated by your friends, romantic partners, etc.?”

### Help Them Make Pregnancy and Childbearing More Concrete.

- Ask questions specifically about how pregnancy and childbearing might impact their current situation. These conversations can emphasize that pregnancy can be planned and should be for the health of a parent and child.

### Support Planning for the Future :

- Transition planning is key to a youth who is considering leaving the foster care system at the age of 18 or considering extended care. Transition planning should include topics such as: birth

## ASK

potential questions...



control options, plans for pregnancy/parenting, relationships, and goal-setting. When discussing transition planning with your teen bring up these topics and utilize the resources included in this guide to help facilitate a positive discussion.

- Pregnancy can be planned and prevented! Let the youth know that pregnancy isn’t a bad thing, while also acknowledging the extreme responsibilities that parenting entails. (Tip: If the youth has younger siblings or babysitting experience, use that as a conversation starter about the responsibilities of a child.) Emphasize that pregnancy can be planned and should be for the health of a parent and child.

### Be Inclusive!

- It is at this time in a teen's life when they are trying to identify themselves. Whether your teen identifies as LGBTQ, a parent, or with another identity, be respectful of that and use inclusive language. *(Remember: Having this conversation with males is equally important as females, young men should understand the personal, financial, and legal obligations of fatherhood.)*

### Don't Impose Your Values.

- Young people—especially adolescents—are very sensitive to judgment and won't be as open or confiding if they feel as though you are judging them. Try your best to leave your personal values at the door and know that being objective is in the best interest of the youth.



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“WHEN

A JUDGE'S GUIDE TO PREGNANCY

YOU

PREVENTION AMONG FOSTER YOUTH

DECIDE...”

WITH BENCH TOOLS AND SCRIPTS

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# BACKGROUND

In 2008 The National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign) partnered with the National Council of Juvenile and Family Court Judges (NCJFCJ) to survey juvenile and family court judges on issues related to preventing teen and unplanned pregnancy. The effort resulted in a guide entitled *Critical Judgment: How Juvenile and Family Court Judges Can Help Prevent Teen and Unplanned Pregnancy*.

As a follow up to this work, in 2010 The National Campaign and NCJFCJ brought together judges from across the country to recommend steps to prevent teen and unplanned pregnancy in the foster care and juvenile justice systems. The judges recommended developing a tool to assist them in preventing teen and unplanned pregnancy, which resulted in the creation of the Technical Assistance Bulletin, *When you Decide... A Judge's Guide to Pregnancy Prevention Among Foster Youth* completed in 2011. Two NCJFCJ Model Court sites, Miami-Dade and Los Angeles, were selected to pilot and provide feedback from March 2012 to October 2013. What follows is an updated toolkit based on the experiences of Miami-Dade and Los Angeles, as well as feedback from other judges in the field.

## COMFORT LEVEL WITH TEEN PREGNANCY PREVENTION

Depending on the individual and the context, both youth and judges will have different levels of comfort discussing sex and pregnancy in the courtroom. When implementing the recommendations in this toolkit, the judge and collaborative stakeholders (e.g. case workers, probation officers, Court Appointed Special Advocate, etc.) can decide where the court wishes to fall on the continuum of privacy for foster youth and comfort levels discussing sex and pregnancy in the courtroom. For example, the judge may consider asking broader questions of agency staff or requesting more specific orders regarding the content of the case report submitted to the court. The judge may also develop modifications to questions depending on whether the youth is a female or a male. Judges may also look to their opposite sex colleagues for advice and support. Judges should not be shy about discussing sex and pregnancy prevention with case stakeholders, either directly or with the assistance of support staff.

To learn more about how other judges have approached this issue in their court rooms, refer to *Critical Judgment: How Juvenile and Family Court Judges Can Help Prevent Teen and Unplanned Pregnancy* (available at [TheNationalCampaign.org](http://TheNationalCampaign.org)), a publication from The National Campaign to Prevent Teen and Unplanned Pregnancy and the National Council of Juvenile and Family Court Judges.

## HOW TO USE THIS TOOLKIT

Judges play an important role in ensuring that youth get the support, knowledge, and tools needed to make healthy long-term decisions regarding sex and reproduction. Three critical inquiries from the judge—**Relationships, Knowledge, and Motivation**—can support an environment in which pregnancy is delayed.

This toolkit does not require that specific questions related to sexuality or reproductive health be directed to youth on the record in the courtroom. Rather, this toolkit supports judges in ensuring that appropriate system stakeholders focus on sexual and reproductive health as an integral part of the youth's case plan and that youth receive the support, knowledge, and tools needed to make healthy long-term decisions regarding sex and pregnancy planning.

This toolkit likely has similar questions to those already asked by judges using other bench tools and can be inserted into a bench book or used with existing bench cards to streamline questions asked during the following hearings:

- » Initial Hearing
- » Dispositional Hearing
- » Review Hearing
- » Permanency Hearing



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# TECHNICAL ASSISTANCE BULLETIN



## INTRODUCTION

Teen pregnancy has significant consequences—many of which are negative—for both the young parents and the baby. This is especially true for youth in foster care. Removed from their families and facing an uncertain future, youth in foster care are less prepared to make informed, responsible decisions about sex and family formation and more likely than their non-foster care peers to engage in sex at an earlier age and become pregnant or cause a pregnancy.

Judges in dependency proceedings are in a unique position to help foster youth make informed reproductive health decisions (See *On Judicial Oversight—Relationships, Knowledge, and Motivation* on page 23). In particular, judges have the authority and the responsibility to ensure that youth are present and heard from at each hearing, and that case plans for youth include support of caring, trusted adult relationships; plans for the foster youth’s future; and developmentally-appropriate reproductive health information. Having these elements in place are key to helping foster youth make their own responsible decisions to delay sex and postpone pregnancy.

The contents of this toolkit were developed based on suggestions and feedback from judges in sites that piloted the initial version. It is designed to guide judges in both on-the-bench hearings and off-the-bench collaborative processes by setting forth a framework—relationships, knowledge, and motivation—with which youth are more likely to make good reproductive health decisions. Finally, it suggests questions to ask from the bench that can best ensure the framework is in place in all aspects of the youth’s life in care. By asking the right questions at every hearing, judges can ensure that each stakeholder in the case fulfills his or her responsibility to take the steps necessary to support youth in making responsible decisions about sex and pregnancy.

## Include Boys

While girls who become pregnant experience different consequences than boys who cause a pregnancy, **it is vital that the judge place equal emphasis on pregnancy planning and prevention among both genders.**

The court should equally focus on integration of sexual and reproductive health in the case plans of boys as well as those of girls through inquiry and promoting healthy relationships with appropriate adults, access to sexual and reproductive health information, and the foster youth’s long-term plans and motivations. **Boys should also fully understand their responsibilities to any child they may father, both personally and legally.**

It is important to note that this tool does not require specific questions related to sexuality or reproductive health be directed to youth on the record in the courtroom. Each court will have its own culture and comfort level in dealing with issues of sexuality and reproductive health.

However, it is strongly recommended that youth be encouraged to attend hearings and thoughtfully discuss sexual and reproductive health in a way that does not infringe on their privacy and that focuses on three key factors: relationships, knowledge, and motivation. Judges should be aware that, as of the publication of this toolkit, no state limits or prohibits discussion of reproductive health options with foster youth. If a stakeholder claims that a policy prohibiting discussion of reproductive health options with foster youth exists, judges should ask for a copy of the “policy” which restricts discussion so that the court can fully understand the restriction. For more information, please see *Rights of Minors in Foster Care* on page 31.

## SEX, PREGNANCY, AND BIRTH: YOUTH IN FOSTER CARE

Youth in foster care face more challenging circumstances and experience less positive outcomes with respect to risk for early pregnancy than youth in the general population. Although there is no national-level data on pregnancy among youth in foster care, studies indicate that, as compared with their peers outside the foster care system, youth in foster care begin having sexual intercourse at a younger age, are more likely to become pregnant or father a child at a young age, and are more likely to carry a pregnancy to term.<sup>1</sup>

A Midwestern study of former foster youth showed that one-third of the females became pregnant before age 17, and nearly half by age 19; this is 2.5 times the rate for their non-foster peers.<sup>2</sup> By age 19, youth in foster care were more than twice as likely as all youth to have given birth to a child.<sup>3</sup> And 46% of youth in foster care who have been pregnant once have had a subsequent pregnancy while still a teen, as compared to 29% of their non-foster peers.<sup>4</sup> Foster youth also report having intercourse with a partner who has a sexually transmitted infection (STI) at three times the rate of non-foster care youth.<sup>5</sup>

Pregnancy has even more profound consequences for teens growing up in foster care than for their non-foster peers. As Miami Judge Jeri Cohen put it, “[w]hen the girls get pregnant they are unable to effectively utilize all the other services that we offer them.”<sup>6</sup>

## FOSTER CARE AND THE INTENT TO HAVE A BABY

When working with youth in foster care, it is important to understand that some youth in care may want to get pregnant.

To some, having a baby is a way to:

- » Find a meaningful relationship.
- » Create a family.
- » Sustain relationships.
- » Achieve a sense of stability.
- » Get closer to their birth family.
- » Receive unconditional love.
- » Become successful and achieve more (more motivated due to baby).
- » Show that they can do better than their birth parents.

This means that a judge and stakeholders cannot assume when working with youth in care that a pregnancy is an accident or something to be avoided. Consider these factors when talking with youth in foster care about reasons to avoid early pregnancy. Stakeholders may consider working with youth in care to identify ways to fulfill these needs without having a baby.

“ [Foster families are] not really related to you biologically at all. Or living in groups homes. Like none of them girls in there; you don’t know them. **And a baby that’s yours, that’s your family, that’s like something you can relate to.** ”

*(Fostering Hope: Preventing Teen Pregnancy Among Youth in Foster Care)*

See page 12 for sources.

It is also true that some youth in care will be parents when they enter the child welfare system and may be at risk for a subsequent teen pregnancy and birth. In fact, by age 19, nearly half of females in foster care have had a subsequent pregnancy compared to less than one-third of females not in foster care.

### SEXUAL ABUSE AND TRAUMA: MEETING THE REPRODUCTIVE HEALTH NEEDS OF FOSTER YOUTH

All youth in foster care have experienced trauma on some level—at a minimum, they have been removed from their homes—youth may also have experienced sexual abuse. Discussing issues related to sex, reproductive health, pregnancy, and contraception may trigger trauma cues like flashbacks or bad memories. The youth may respond by exhibiting such negative behavior as spacing out, constant movement, acting out, and/or struggling to manage emotions in both the courtroom and other places that remind them of the traumatic experience. It is important to understand that trauma may be why the youth is acting out and not to misinterpret these behaviors as disrespectful or negative; they are often an unconscious response that has been triggered by memories of prior trauma.

For foster youth who disclose a history of sexual abuse it is critical to identify counselors and therapists who can work with the youth, and then follow their professional guidance as to how and when to discuss sex, reproductive health, pregnancy, and contraceptive methods and access.

## KEY TO PREVENTION: GIVING YOUTH THE TOOLS TO MAKE GOOD DECISIONS

Teen pregnancy is the result of a series of decisions about sex, with numerous opportunities to guide decision-making with positive prevention measures. For example, before a youth becomes pregnant or causes a pregnancy, she or he engages in sexual activity, which may or may not include intercourse. Pregnancy (and possibly an STI) could be the result of a larger, more complicated process, involving several decisions along the way, each of which is an opportunity to make a choice.

Some of these choices are:

- » Initiation of sexual activity.
- » Whether and when to have intercourse.
- » Frequency of sexual intercourse.
- » Number of partners.
- » Choice of partners and quality of relationships.
- » Whether and how to take action to prevent pregnancy and STIs.

The recent decline in teen pregnancy rates in the U.S. highlights the importance of focusing on the entire timeline of decisions. Research indicates the decline has resulted, in part, from behavioral changes in two distinct areas: delayed initiation of sexual intercourse and improved contraceptive practice.<sup>7</sup> Youth have been making different—and better—decisions about their reproductive health.

Adults can support good decision-making among youth in foster care. In particular, they can create an environment that communicates the importance of waiting to have a baby, provides the youth with complete and accurate information, and helps the youth to take responsibility for each of the decisions that may lead to pregnancy. Three factors play a critical role in the development of good decision-making skills that will help youth postpone sex and pregnancy: **relationships, knowledge, and motivation.**

It is crucial that youth be encouraged to attend and be heard at each hearing, if they want to and are comfortable doing so. The youth may not be willing to talk about sex and relationships, wanting instead to guard their privacy during a time when many people are making decisions for them. The judge should be prepared to modify how the court receives information about progress on the three decision-making skills factors—relationships, knowledge, motivation—to safeguard the youth's privacy.

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See page 12 for sources.

## RELATIONSHIPS AND ASKING THE RIGHT QUESTIONS

One of the most important factors in preventing teen pregnancy is a supportive relationship between the youth and a caring, trusted adult. That caring adult can help to communicate with youth about the importance of delaying sex and being prepared for pregnancy and parenthood. They can also help the youth learn about healthy relationships and provide a link to clinical services, if appropriate.

Many years of research have confirmed that parents are a primary influence on a youth's decisions about sex. Youth who are close to their parents are more likely to postpone sex, to have fewer sexual partners, and to use contraception consistently.<sup>8</sup> Studies have consistently shown that parents' values influence whether youth have sex, how old they are when they have sex for the first time, the number of sexual partners they have, their use of contraception, and whether or not they become pregnant.<sup>9</sup>

Monitoring and supervision are also related to lower teen pregnancy rates, primarily by decreasing the opportunity for sexual activity, particularly early sexual activity.<sup>10</sup> This is especially important given that youth who have sex in their early teens have more sexual partners, are less likely to use contraception, and are more likely to become pregnant.<sup>11</sup> Supervision can also include restrictions on age differences in youth relationships, which in turn affects sexual activity; teens who have a partner close to them in age are far less likely to have sexual intercourse than a young teen with a partner two or more years older.<sup>12</sup>

Foster youth are the first to point out the obvious absence of strong relationships with caring, supportive adults as a major factor affecting their ability to make good decisions about sex and pregnancy prevention.<sup>13</sup> A youth living in a non-relative foster placement is separated not only from parents but also frequently from extended family, school friends, peers, and mentors. The youth must often change schools and churches, cutting off contact with teachers, coaches, or pastors who may have played a supportive role in his or her life.

Many adult stakeholders assume responsibility for the wellbeing of a youth placed in foster care:

- » **Child welfare staff** must develop a case plan to meet the youth's need for safety, health, education, and permanency.
- » A **lawyer or guardian ad litem** will advocate for the youth in court.
- » **Foster parents** or **group home staff** will provide a safe, nurturing environment.
- » The **behavioral health service provider** will address the youth's mental health needs.
- » The **Court Appointed Special Advocate (CASA)** will advocate for the youth's best interests in court.
- » The **judge** will ensure that the stakeholders make reasonable and timely efforts to provide the youth with necessary and appropriate services to achieve the permanent case plan goal.

No one individual is charged with filling the role that a parent would ordinarily be expected to play by developing a relationship based on trust and confidence that guides youth in making major life decisions.

The foster care system must either:

**A** - support or facilitate a youth's relationship with caring adults who might not be able to provide a home for the youth but may nonetheless serve as a mentor or confidant; or

**B** - adult stakeholders must step into that role.

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See page 12 for sources.

# FROM THE BENCH CARD: ASKING THE RIGHT QUESTIONS ABOUT RELATIONSHIPS

The judge should ask if the youth is present. If not, the judge should determine why not and what can be done to make sure the youth attends in the future. If the youth is present, the judge should be prepared to engage the youth by asking questions about placement, caring adults, school, extracurricular activities, and future plans.

At the first hearing and at each subsequent hearing, the judge should receive the answers to the following questions, either from reports submitted to the court or through questioning during the hearings:

- Who is the trusted adult in the youth's life with whom the youth has a positive relationship?
- Who have the parents identified as extended family members and other support persons?
- Who has the youth identified as family and support persons, and specifically, adults with whom the youth may be able to communicate effectively about intimate topics such as sex, love, and relationships?
- What other action has been taken to identify and engage family and support persons, by whom, and when?
- What barriers, if any, are there to participation, and what is being done to overcome those barriers?
- Which of the important adults in the youth's life (including foster parents, agency staff, youth's attorney, and CASA) have received information and training on how best to communicate with the youth about decision-making in general, and sexuality and relationships in particular?
- Which important adults are working closely together, coordinating their support of the youth and monitoring the youth's activities and friendships?
- What services are being provided to help the youth develop a healthy relationship with the parents?
- What training has been provided to the caring adult for effective developmentally appropriate communication about values, healthy relationships, reproductive health information, and information and access to contraceptive methods?



## THE JUDGE'S ROLE: FOCUS ON RELATIONSHIPS

The judge can ensure that stakeholders are either supporting and facilitating existing relationships with caring, trusted adults, or stepping into the role with appropriate training and skills.

The first thing the judge can do is make sure the youth is present at each hearing, and give the youth an opportunity to speak at each hearing. Beginning at the initial hearing, the judge can ensure that:

- » The agency staff and all participants focus on identifying the important and appropriate adults in the youth's life and promoting and strengthening those relationships.
- » Everyone working with the youth, including the agency staff, is trained to understand reproductive health issues, be supportive of the youth, and communicate effectively in a developmentally appropriate way.

**Facilitating and Supporting Existing Relationships.** Stakeholders involved in the case should be encouraged to think about this issue broadly. Both maternal and paternal relatives should be considered as a possible placement for the youth, and for involvement in the case in other ways. Relatives and other caring adults can provide positive support to the youth in a variety of areas and may be able to facilitate visitation between the youth and his or her parents or siblings, host the youth for visits during holidays, attend athletic events or school functions, serve as a mentor, support the youth in case planning meetings and hearings, or just visit on a regular basis.

**Stakeholders Taking on the Caring Adult Role.** Sadly, in too many cases, the only constant person in a foster youth's life will be the case stakeholders. Particularly in these circumstances, it is important that the stakeholders have the training and skills to be able to communicate effectively with the youth and develop a relationship of mutual trust.

Both the stakeholders and the existing caring adult should receive training on how to effectively communicate with the foster youth about developmentally appropriate reproductive health information and values, as well as how to support use and access to a full range of contraceptive methods.

## KNOWLEDGE AND ASKING THE RIGHT QUESTIONS

To make good decisions about preventing pregnancy foster youth need—but may not be getting—comprehensive, accurate information from reliable sources about sex, reproductive health, pregnancy, and contraception.

The National Center for Health Statistics (NCHS) reports that virtually all adolescents receive some formal sex education before they are 18.<sup>14</sup> In that same survey, one-third of adolescents report that they were not taught anything about methods of birth control,<sup>15</sup> even though most teens believe they should be getting information about both abstinence and contraception, or contraception alone.<sup>16</sup>

Although 59% of older youth believe that doctors are their most trusted source of information about contraception, almost half rely on less trusted sources for their knowledge: the media and their friends.<sup>17</sup> It is not surprising, then, that a significant minority reports little or no knowledge about common methods of contraception.<sup>18</sup> Youth appear to have a limited and sometimes incorrect understanding of basic concepts of sexual reproduction:

- » Most older youth know that a woman is more fertile at certain times of the month, BUT less than one-third correctly identified when that time is.<sup>19</sup>
- » Sixteen percent erroneously believe that it is quite or extremely likely that they themselves are infertile.<sup>20</sup>
- » Close to half of teens surveyed wrongly believe that there is a 50% chance of getting pregnant even when correctly using the birth control pill.<sup>21</sup>

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See page 12 for sources.

- » Half of older youth and one-third of all youth agree with the statement: “It doesn’t matter whether you use birth control or not; when it is your time to get pregnant, it will happen.”<sup>22</sup>
- » Three-quarters of this same group also report that “I have all the information I need to avoid an unplanned pregnancy.”<sup>23</sup>

There is a disconnect between youth’s perceptions and beliefs and the facts. Comprehensive, accurate information from reliable sources about sex, reproductive health, pregnancy, and contraception is needed to bridge this knowledge gap.

Similarly, there is a knowledge gap related to the consequences of pregnancy and parenting. Surveys indicate that most youth agree that it is okay for a single female to have a baby.<sup>24</sup> In 2007, almost half of youth surveyed reported that they had never really thought about what their life would be like if they got pregnant or got someone pregnant as a teen.<sup>25</sup>

To close this gap, the trusted caring adult in the youth’s life—whether it is an existing relationship or another qualified adult stepping into the role—must be prepared to be the source of developmentally appropriate, reliable information. To best prepare these important adults, thorough training is paramount.

### THE JUDGE’S ROLE: FOCUS ON KNOWLEDGE

Responsible parents don’t wait until their child is almost an adult to begin a conversation about sex, reproductive health, pregnancy, and contraceptive methods, and access. Similarly, stakeholders should not wait until the youth is aging out of the foster care system to share this information. Foster youth report that they have some access to information on these issues but some report that it is too little and too late.<sup>26</sup>

Discussion, planning, and taking action to support the reproductive health of youth in foster care should begin early, at puberty or, at least, before the youth enters high school. In 2013, 46% of children in foster care were between the ages of 10 and 20 years old which means the work should begin by the first court hearing.<sup>27</sup>

Because a foster youth is continually maturing, developmentally appropriate discussions with a caring, trusting adult should take place multiple times throughout the youth’s adolescence. This enables the youth to regularly receive information on these topics throughout their lives. Information sharing should not happen just once.

All foster youth are entitled to receive regular health screenings. Agency staff should ensure that, as the youth enters puberty, those screenings include an examination and age-appropriate reproductive health and pregnancy prevention information, including information about methods of contraception and how and where to get it.

The judge should specifically order that these steps be included in the youth’s case plan, and ask if the youth has a doctor with whom a positive relationship exists. The judge should ensure that the case plan provides for:

- » Developmentally-appropriate information shared by a caring trusted adult starting at puberty (or earlier).
- » Appropriate reproductive medical screening and services.
- » Evidence-based education that promotes informed decisions about sex, delaying sex, pregnancy, and effective use of contraception.
- » Easy access to appropriate methods of contraception.
- » Stakeholders should be aware of the youth’s potential involvement in sexual activity; for example, when a youth begins dating or reports that he or she is involved in a romantic relationship. The supportive adults must follow-up with the youth on the reproductive health information received, and ensure access to reproductive health care and contraception as well as reiterating effective ways to prevent pregnancy and STIs.

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See page 12 for sources.

# FROM THE BENCH CARD: ASKING THE RIGHT QUESTIONS ABOUT KNOWLEDGE

The judge should ask if the youth is present. If not, the judge should determine why not and what can be done to make sure the youth attends in the future. If the youth is present, the judge should be prepared to engage the youth by asking questions about placement, caring adults, school, extracurricular activities, and future plans. The judge should inform stakeholders of the expectation that information about sex, reproductive health, pregnancy, contraceptive methods, and access to contraceptives will be shared with the foster youth and reported on at hearings.

At subsequent hearings the judge should have answers to the following questions, either from reports submitted to the court, or through questioning during the hearing:

- Who is responsible for providing the foster youth with developmentally-appropriate and ongoing information on sex, pregnancy, reproductive health, contraception methods, contraception access, STI prevention, and healthy relationships?
- What comprehensive and accurate information has been shared with the foster youth?
- Which physician has the youth been referred to for age- and developmentally- appropriate reproductive health screenings and pregnancy prevention information?
- When did or will the youth complete an evidence-based sex education program that included complete and accurate information about reproduction, STIs, abstinence, and contraception?
- How does the youth access contraception? What steps have been taken so access is ongoing, ready, and non-judgmental? Who provided the youth with information on how to use contraception effectively and consistently?

The case plan should also provide information on the training for relative placements and other significant adults—especially foster parents—on how to responsibly and effectively communicate with youth about making good decisions specifically with regard to sexuality, reproductive health, pregnancy, contraception, and relationships.

The judge should be alert to whether the agency staff and the youth’s placement have a good working relationship, and that both are setting appropriate boundaries and expectations for the youth and monitoring his/her activities and friendships.

## MOTIVATION AND ASKING THE RIGHT QUESTIONS

Healthy relationships with caring, trusted adults and ongoing, developmentally-appropriate knowledge are not enough to help a foster youth make good decisions. The issues that emerge with sexual maturation arise at a time when adolescents are making decisions in other major areas of their lives, such as:

- » What are my life goals?
- » What kind of career do I want?
- » Will I continue my education, and in what form?
- » Who will my friends be?
- » Will I use alcohol or drugs, or engage in other risky behavior?

Youth must also be motivated to avoid pregnancy. Motivation to make careful decisions is tied to the ability to envision a bright future, the knowledge of how to achieve that future, and recognition of how today’s decisions might affect that future. A youth who has a real vision of their future and is motivated to forego short-term opportunities to achieve long-term goals is more likely to make responsible decisions about sex and pregnancy. In other words, for those who choose to engage in sexual intercourse, “there must be some compelling reason for them to master contraceptive information and go to the trouble it takes to use birth control carefully and consistently.”<sup>28</sup>

Youth growing up in adverse circumstances may not see a positive future for themselves—or, even if they do, they may lack the support needed to believe that they can achieve that future. Programs designed to prevent teen pregnancy are more likely to succeed if they also help youth develop the skills needed to become successful adults. “By engaging teens in meaningful activities, making them feel competent, and helping them develop valuable skills, youth development groups give kids a sense of hope in their future—[which is] the greatest incentive to remain pregnancy-free.”<sup>29</sup>

Planning for the future is not something a foster youth may be interested in or able to do until life has stabilized. Achieving placement, educational, and extra-curricular stability is key to the ability to plan for the youth’s future. Services supporting each of these priorities should be included in the case plan and should be reviewed at every case staffing and hearing, with input from the youth and the caring adults with whom the youth is connected.

First, the youth must have a stable placement in a safe, nurturing environment, preferably with a relative or other caring adult, and with siblings (if applicable). If a full and complete effort is not put into finding an appropriate placement, the placement is likely to disrupt. Every disruption delays and impedes the development and implementation of an effective plan for the youth’s future; therefore, agency staff should identify and put in place the assistance needed to support and maintain the placement.

Second, the youth must have educational stability. Every youth must enroll in and attend an educational or vocational program, and—to the extent possible depending on his or her best interest—the youth should remain in the familiar environment of his or her home school. The importance of the judge’s role in ensuring that the educational needs of youth in foster care are met has been well documented.<sup>30</sup> By discouraging changes in school placement (and the resultant setbacks in educational progress) the judge can celebrate the youth’s achievements in school and work towards eliminating barriers and challenges.

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See page 12 for sources.

Third, the youth must have stability in the extra-curricular activities, such as involvement with a church youth group, participation in athletic activities, or involvement in interest-based clubs or hobbies. Engaging in these activities will enable youth to explore and build upon interests, helping to frame their short- and long-term goals and provide motivation to avoid negative outcomes.

As the youth matures—but well before he or she approaches emancipation—the case manager and other adults identified by the youth should assist in developing a detailed plan for transitioning to independent living and ultimately into adulthood. The plan should address the major adult life markers: housing, employment, education, and health (in particular, reproductive health).

### **THE JUDGE'S ROLE: FOCUS ON MOTIVATION**

In accordance with federal law, the judge should ensure that the child welfare agency works with the youth to develop comprehensive transition plans (as appropriate), including independent living skills training (housing, education, career, and reproductive health) and provide services that are necessary and appropriate to achieving that plan.

At each hearing, the judge can discuss with the youth his or her life goals, identify the steps needed to achieve those goals, and walk through how short-term decisions (including the decision to engage in unprotected sex) can affect long-term aspirations (See *On Foster Youth Participation in Court* on page 21).

The judge can also serve as a pro-active supporter of the youth's goals, asking the youth about progress towards his or her stated goals, celebrating his or her successes, and helping him or her problem solve any barriers that may have arisen in meeting those goals.

## **CONCLUSION**

Engaging in sexual activity and having a baby are major milestones in life. For youth and young adults, the earlier these occur, the more potential for negative long-term consequences. Ultimately, adults cannot control a youth's sexual behavior, but they can have a powerful impact on their decision-making by communicating the value of postponing sex and pregnancy, and by providing them with comprehensive, accurate information; health care; and ready access to contraception. More importantly, they can help the youth to envision a bright future and support them as they work to make good decisions.

The juvenile judge plays an important role in ensuring that the youth's case plan provides for his or her safety, wellbeing, and permanency. This includes having specific provisions to address reproductive health and pregnancy prevention through the support of long-term relationships with caring adults, comprehensive sex education, access to reproductive health services and contraception, and support of the youth's long-term plans to transition to adulthood. By including the youth in the planning and review process and asking the right questions at every hearing, the judge can make certain that all stakeholders are making a reasonable effort to support the youth in learning to make informed decisions about when he or she is ready for sexual activity and pregnancy.

# FROM THE BENCH CARD: ASKING THE RIGHT QUESTIONS ABOUT MOTIVATION

The judge should ask if the youth is present. If not, the judge should determine why not and what can be done to make sure the youth attends in the future. If the youth is present, the judge should be prepared to engage the youth by asking questions about placement, caring adults, school, extracurricular activities, and future plans.

During regular reviews of the case, the judge should have answers to the following questions, either from reports submitted to the court, or through questioning during the hearing:

- How stable is the youth's placement? Is the youth placed with a relative or other caring adult who has a supportive relationship with the youth?
- If not, what efforts are being made to identify an appropriate relative or caring adult to achieve a stable placement?
- What reasonable efforts have been made to place siblings together?
- What, if any, support is needed to maintain the youth in a stable placement? Who is responsible for providing this support? By when?
- Where is the youth enrolled in school? How stable is the youth's educational placement?
- If the youth was moved from his or her home school, why is that in the youth's best interest?
- What has been done to ensure the continuity of education credits, extracurricular activities, etc.?
- What are the youth's life goals? How are those being supported by stakeholders?
- Who has reviewed the youth's educational records, assessed the youth's performance, and ensured that the youth is receiving any necessary remedial or educational support services?
- What extracurricular activities is the youth engaged in? What efforts are being made to maintain stability in the youth's participation in extracurricular activities?
- What supports and services are in place to maintain the stability of the youth's placement, education, and extracurricular activities?
- What supports and services are in place to assist the youth with independent living skills (housing, education, employment, reproductive health) and transition planning?

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# TRAINING RECOMMENDATIONS AND RESOURCES





# TRAINING RECOMMENDATIONS

A key theme in the feedback from the pilot project was the need for training of both stakeholders and caring adults in the lives of young people related to:

- » Who, where, and how to talk about reproductive health and safety with foster youth in a developmentally appropriate way.
- » What services are available to the foster youth.
- » Understanding why a foster youth might want a baby.
- » Understanding the effect of sexual abuse and trauma on sexuality and reproductive health.

## RESOURCES

### FAST FACTS: TEEN PREGNANCY IN THE UNITED STATES

Our *Fast Facts* fact sheet series details data on teen pregnancy, birth, and childbearing including information on:

- » race and ethnicity,
- » sexual behavior,
- » contraceptive use,
- » and trends in the United States.

Learn more at [TheNationalCampaign.org](https://www.thenationalcampaign.org).

### TEEN BIRTH RATE

Provides state rankings and their corresponding teen birth rate (overall, not broken down by race/ethnicity, age, etc.) and U.S. overall teen birth rate.

Learn more at [TheNationalCampaign.org/data](https://www.thenationalcampaign.org/data).

### TEEN PREGNANCY RATE

Provides state rankings for teen pregnancy and their corresponding rate (overall, not broken down by race/ethnicity, age, etc.) and U.S. overall teen pregnancy rate.

Learn more at [TheNationalCampaign.org/data](https://www.thenationalcampaign.org/data).

### TOOLS FOR JUDGES:

From the Bench: Full Bench Cards .....	page 15
Quick Reference Guide Bench Card .....	page 19
On Foster Youth Participation in Court .....	page 21
On Judicial Oversight—Relationships, Knowledge, and Motivation .....	page 23
Rights of Minors in Foster Care .....	page 31
Sample Scripts .....	page 33
Seven Things You Can Do to Help Prevent Pregnancy among Foster Youth .....	page 37

### AVAILABLE AT THENATIONALCAMPAIGN.ORG:

*Critical Judgment: How Juvenile and Family Court Judges Can Help Prevent Teen and Unplanned Pregnancy*

*Why it Matters* (a fact sheet series on the consequences of teen pregnancy)

## TOOLS FOR SYSTEM STAKEHOLDERS

(i.e. case managers, probation officers, social workers, CASA):

Outside the Court Room: Working with Youth to Address Reproductive Health .....	page 25
Rights of Minors in Foster Care .....	page 31
Sample Scripts .....	page 33

### AVAILABLE AT THENATIONALCAMPAIGN.ORG:

*Help Me to Succeed: A Guide for Supporting Youth in Foster Care to Prevent Teen Pregnancy*

*Talking Back: What Teens Want Adults to Know About Teen Pregnancy*

*Pocket Protector: A Guide to Birth Control Options*

### TOOLS FOR FOSTER YOUTH:

**Bedsider.org** (website for young people age 18–29)

**StayTeen.org** (website for teens age 13–17)

**StayTeen.org/health-centers** (Stay Teen Health Center Finder)

### AVAILABLE AT THENATIONALCAMPAIGN.ORG:

*It's Your Call: Make the Right Decision for You*

*Pocket Protector: A Guide to Birth Control Options*

## TOOLS FOR PARENTS, FOSTER PARENTS, CAREGIVERS

### AVAILABLE AT THENATIONALCAMPAIGN.ORG:

*10 Tips for Foster Parents to Help Their Foster Youth Avoid Teen Pregnancy*

*10 Tips for Parents To Help Their Children Avoid Teen Pregnancy*

*A Crucial Connection: Working Together to Address Teen Pregnancy Among Youth in Foster Care*

*Fostering Hope: Preventing Teen Pregnancy Among Youth in Foster Care*



# FROM THE BENCH: FULL BENCH CARDS



# FROM THE BENCH: FULL BENCH CARDS

The judge should ask if the youth is present. If not, the judge should determine why not and what can be done to make sure the youth attends in the future. If the youth is present, the judge should be prepared to engage the youth by asking questions about placement, caring adults, school, extracurricular activities, and future plans.

The judge should inform stakeholders of the expectation that information about sex, reproductive health, pregnancy, contraceptive methods, and access to contraceptives will be shared with the foster youth and reported on at hearings.

**At the first hearing and at each subsequent hearing, the judge should receive the answers to the following questions**, either from reports submitted to the court or through questioning during the hearings.

## QUESTIONS ABOUT RELATIONSHIPS

- Who is the trusted adult in the youth's life with whom the youth has a positive relationship?
- Who have the parents identified as extended family members and other support persons?
- Who has the youth identified as family and support persons, and specifically, adults with whom the youth may be able to communicate effectively about intimate topics such as sex, love, and relationships?
- What other action has been taken to identify and engage family and support persons, by whom, and when?
- What barriers, if any, are there to participation, and what is being done to overcome those barriers?
- Which of the important adults in the youth's life (including foster parents and the agency staff, youth's attorney, and CASA) are receiving information and training on how best to communicate with the youth about decision-making in general, and sexuality and relationships in particular?
- Which important adults are working closely together, coordinating their support of the youth and monitoring the youth's activities and friendships?
- What services are being provided to help the youth develop a healthy relationship with the parents?
- What training has been provided to the caring adult for effective developmentally appropriate communication about values, healthy relationships, reproductive health information, and information and access to contraceptive methods?

## QUESTIONS ABOUT KNOWLEDGE

- Who is responsible for providing the foster youth with developmentally-appropriate and ongoing information on sex, pregnancy, reproductive health, contraception methods, contraception access, STI prevention and healthy relationships?
- What comprehensive and accurate information has been shared with the foster youth?
- Which physician has the youth been referred to for medical screenings and age- and developmentally- appropriate reproductive health and pregnancy prevention information?
- When did or will the youth complete an evidence-based sex education program that included complete and accurate information about reproduction, STIs, abstinence, and contraception?
- How does the youth access contraception? What steps have been taken so access is ongoing, ready, and non- judgmental? Who provided the youth with information on how to use contraception effectively and consistently?

## QUESTIONS ABOUT MOTIVATION

- How stable is the youth's placement? Is the youth placed with a relative or other caring adult who has a supportive relationship with the youth?
- If not, what efforts are being made to identify an appropriate relative or caring adult to achieve a stable placement?
- What reasonable efforts have been made to place siblings together?
- What, if any, support is needed to maintain the youth in a stable placement? Who is responsible for providing this support? By when?
- Where is the youth enrolled in school? How stable is the youth's educational placement?
- If the youth was moved from his or her home school, why is that in the youth's best interest?
- What has been done to ensure the continuity of education credits, extracurricular activities, etc.?
- What are the youth's life goals? How are those being supported by stakeholders?
- Who has reviewed the youth's educational records, assessed the youth's performance, and ensured that the youth is receiving any necessary remedial or educational support services?
- What extracurricular activities is the youth engaged in? What efforts are being made to maintain stability in the youth's participation in extracurricular activities?
- What supports and services are in place to maintain the stability of the youth's placement, education, and extracurricular activities?
- What supports and services are in place to assist the youth with independent living skills (housing, education, employment, reproductive health) and transition planning?







# QUICK REFERENCE GUIDE BENCH CARD



# QUICK REFERENCE GUIDE BENCH CARD

**The judge should ask if the youth is present. If not, the judge should determine why not and what can be done to make sure the youth attends in the future.**

The questions below can be asked of the youth themselves or system stakeholders to ensure that questions related to teen pregnancy prevention are addressed.

- Who are the long-term supportive adults that have been identified in the foster youth's life and how are those relationships supported by the case plan?**

(This could include family members, foster parents, child welfare staff, and other advocates.)

- Who referred the foster youth to a health care provider for a health screening, including STI screening, and information about birth control? What does the foster youth know about how to access these reproductive health services on his or her own?**

(This could include a visit to the health clinic, accessing reliable web resources, or attending an educational program.)

- From where and how does the foster youth have ongoing and ready access to contraception?**

- What are the foster youth's long-term and short-term goals? What conversations have been had with the foster youth about the impact a pregnancy would have on those goals?**





# ON FOSTER YOUTH PARTICIPATION IN COURT



# ON FOSTER YOUTH PARTICIPATION IN COURT

Federal law requires that youth in care be given the opportunity to be heard, and that specialized transition case plans be developed for older youth. In most states, a foster youth is a party to the dependency proceeding and has the right to attend hearings; the judge should encourage the youth to attend unless it is contrary to his or her interests.

Support of participation by foster youth includes setting hearings at times when the youth is not in school or during scheduled extracurricular activities. The judge should ask about who will transport the youth to and from the courthouse for hearings. The judge should also consider alternative forms of participation, such as allowing the youth to participate by phone or through writing a non-ex parte letter.

If the foster youth doesn't attend court proceedings, the judge should ask about the foster youth's absence. The judge should advise the agency staff and counsel that he or she strongly encourages the youth to attend in person. Some judges give the youth, through counsel, a letter or "notice" in youth-friendly language that lets the youth know about the proceeding, the importance of the hearings, and the judge's wish to hear personally from the youth in court.

If the foster youth attends court hearings, this is the beginning of a relationship with another person who can be instrumental in achieving long-term goals. The nature of that relationship is in large measure up to the judge. The youth has probably never been in court before, and it will likely seem strange and troubling that major decisions in the youth's life are being made by a stranger. Even with the best attorney, court process may be intimidating, confusing, and frustrating.

Some judges believe that their role should be no different than it is with any other party. Others believe that it is part of the judge's role in supporting the youth's safety, wellbeing, and stability, to get to know each youth on their caseload, understand their individual needs and goals, and engage their active participation in the proceedings. Whatever the comfort level in connecting with youth in the courtroom, the judge sets an example by establishing a relationship that demonstrates respect for the youth, clarifies what the youth can expect the judge to do, and follows through on those expectations.

## A SUGGESTED INTRODUCTION MIGHT BE:

I'm glad that you've chosen to attend this hearing, and I hope you will come to all of the hearings. I will try to set those hearings at a time when you can attend, so please let me, your lawyer, or your case worker know when you have conflicts.

My job is to make sure that your case worker and the other adults working with you place you in a safe, permanent home. Hopefully, that will be with one of your parents. If not, then we hope to place you with a member of your family or a trusted adult friend. It is also my job to ensure that you maintain your relationships with your brothers and sisters, and with family members who you love and who are helpful and supportive of you. Finally, it is my responsibility to see that all the adults who are responsible for you make sure that you are in school and getting the support you need there, that your health needs are known and met, and that you receive any other services or support that you need.



This case is likely to last for a number of months. Today, and in the coming weeks and months, I will have to make a number of decisions that affect you. I will be reading reports and hearing from the agency staff about what the agency is doing to take care of you and what decisions they want me to make about you. It will help me to make better decisions if I know what you want and what you need. I hope you will feel comfortable telling me that yourself, but if not, tell your lawyer or your case worker and they will tell me. I cannot promise that I will always do what you want me to do. But I can promise that I will listen to your views and consider them very carefully in making my decisions. My priority is your best interest; my goals are to maintain your safety, promote your wellbeing, and find you a permanent home.

The judge should explain any decisions made at the hearing, and make sure the youth understands what will happen at the next hearing, between hearings, and when the next hearing will take place. The judge should also make clear that the agency staff will include the youth in all case planning activities, and affirm with the youth that he or she was included in case planning at subsequent hearings.

The more a judge knows about a youth, the more well informed a decision he or she can make for the youth's benefit. For example, the youth may not feel comfortable taking the initiative to request placement or contact with particular relatives—particularly if those relatives are at odds with his or her parents. But if the judge asks the youth to tell him or her about people who are important in her life, the judge may unearth previously undisclosed information that can help agency staff to locate a relative placement or support person for the youth. This, in turn, can lead to the long-term, healthy adult relationship the youth needs. A casual conversation about the youth's interests can prompt the judge to inquire of agency staff what is being done to support those interests through extracurricular activities.

The judge can also take this opportunity to focus positive attention on the youth. All too often, hearing time is spent on the negatives—placement disruptions, failing classes, fights with roommates. While those issues are important, the judge can also do much to encourage the youth by finding something to praise—consistent attendance at school, active participation in therapy, joining a school athletic team.

The judge can also model the relationships that other stakeholders should develop with the youth: setting expectations, encouraging the youth to accept responsibility for making the important decisions in his or her life, giving the tools to do so effectively, and holding themselves and the foster youth accountable for what they have agreed to do. The judge should review the various elements of the case plan with the youth and explain that he or she is ordering these services be provided so that the youth can develop the ability to succeed as an adult.

With respect to sex and pregnancy, the judge should openly acknowledge that part of the maturation process includes developing sexual and romantic relationships, and explain that part of the case plan is designed to give the information and support needed to make good decisions about sex, including delaying sexual activity and, if engaging in sexual intercourse, taking effective measures to prevent pregnancy and disease (See *Sample Scripts* on page 33 for suggestions).



**ON JUDICIAL  
OVERSIGHT:  
RELATIONSHIPS,  
KNOWLEDGE,  
AND MOTIVATION**



# ON JUDICIAL OVERSIGHT: RELATIONSHIPS, KNOWLEDGE, AND MOTIVATION

The job of a judge is to apply the law and determine whether the conditions of the law have been met based on the facts of a particular case. As a result of three decades of changes to federal child welfare laws, the role of the judge in a dependency case has changed dramatically. Federal law requires the dependency judge to approve the case plan for a youth in foster care, review the plan periodically, and determine whether the child welfare agency is making reasonable efforts to achieve the case plan. A dependency judge should also ensure that foster youth coming before them have been given the tools to make good decisions about sex and their reproductive health (which includes delaying pregnancy and using contraception if sexually active).

In addition to asking basic questions pertaining to the legal status of a child, the judge is also charged with ensuring that the child welfare agency meets its responsibility to providing timely permanency for youth in a safe, nurturing home.

Specifically, after a youth has been deemed dependent, the judge must:

- » Hold disposition, review, and permanency hearings within federally specified timeframes;
- » Determine the appropriate placement for the youth;
- » Approve a permanent case plan goal for the youth;
- » Review the written agency case plan and determine whether the proposed services are necessary and appropriate to achieve the case plan goal; and
- » Review the progress in the case within specified timeframes and determine whether the agency is making reasonable efforts to achieve the case plan goals.

As has been amply demonstrated elsewhere,<sup>1</sup> to fulfill this expanded role a judge must be knowledgeable about the child welfare agency, available community services, and underlying domestic issues such as child abuse and neglect, substance abuse, mental illness, and domestic violence. As the case proceeds, the judge cannot simply monitor progress but must also take affirmative steps to ensure that the goals of the law are met. This includes clarifying roles and responsibilities, setting expectations, establishing timeframes for action, evaluating results, and holding parties accountable.

For example, the importance of early action by the court is reflected in the provision of the Fostering Connections to Success and Increasing Adoptions Act. This Act requires the child welfare agency to identify and provide notice to all adult relatives within 30 days after removal.<sup>2</sup> Often there will be many relatives and friends at the preliminary protective hearing, but when the children are not returned to the parents or placed with one of them immediately, they tend to fade out of the picture. The judge can play a positive role in fostering engagement by relatives by explaining the process to them, encouraging them to identify ways in which can assist the family even if they cannot be a placement, and asking them to provide contact information to the agency staff. This judicial oversight supports facilitating and supporting existing relationships.

The child welfare agency is required to promote educational stability by coordinating with local schools to ensure that youth remain where they were originally enrolled (unless this would be contrary to their best interests). The agency is also required to coordinate with the state Medicaid agency and other medical providers to develop a plan for ongoing oversight and coordination of health care services, including initial and follow-up health screenings and continuity of care. While these stipulations are not required to be a part of the individual

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<sup>1</sup> Publication Development Committee of the National Council of Juvenile and Family Court Judges, Victims of Child Abuse Project, & Grossman, D. E. (1995). *Resource guidelines: Improving court practice in child abuse and neglect cases*. Reno, NV: National Council of Juvenile and Family Court Judges.

<sup>2</sup> 42 U.S. C. § 671 (2010).

written case plan, they are appropriate areas of inquiry for the judge and should inform any decision regarding “reasonable efforts.”<sup>3</sup> This judicial oversight responsibility supports the foster youth’s access to information and knowledge, as well as motivation.

The Act has also added requirements focused on older youth.<sup>4</sup> Where appropriate, there must be “a written description of the programs and services which will help such child prepare for the transition from foster care to independent living” for youth age 16 or older. Within 90 days before the youth turns 18, the case manager must also “provide the child with assistance and support in developing a transition plan that is personalized at the direction of the child” that addresses at a minimum housing, health insurance, education, support services, and employment services.<sup>5</sup> This judicial oversight responsibility supports the foster youth’s motivation after foster care.

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<sup>3</sup> For more background on the educational issues and checklists to assist judges in ensuring that the educational needs of foster children are being met, see *Asking the Right Questions II: Judicial Checklists to Meet the Educational Needs of Children and Youth in Foster Care* (Gatowski, Medina, & Warren, 2008).

<sup>4</sup> The Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (2008).

<sup>5</sup> The Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (2008).



**OUTSIDE THE  
COURTROOM:  
WORKING WITH  
YOUTH TO ADDRESS  
REPRODUCTIVE  
HEALTH**



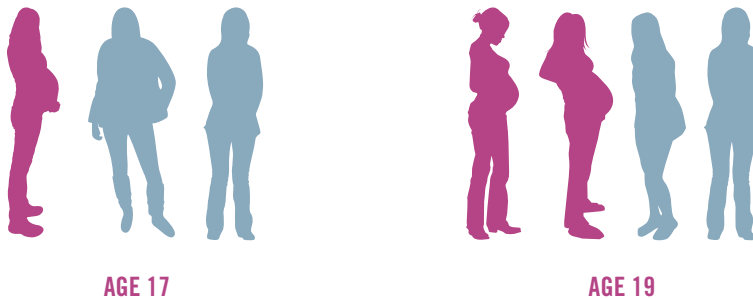
# OUTSIDE THE COURTROOM: WORKING WITH YOUTH TO ADDRESS REPRODUCTIVE HEALTH

Teen pregnancy rates have declined dramatically nationwide over the past two decades. However, disparities remain, particularly for youth in foster care. In fact, the teen pregnancy rate for girls in foster care is more than double the rate for teen girls in the general population. When working with youth, we encourage you to use this tool below to start a conversation and to help teens make good decisions about their reproductive health.

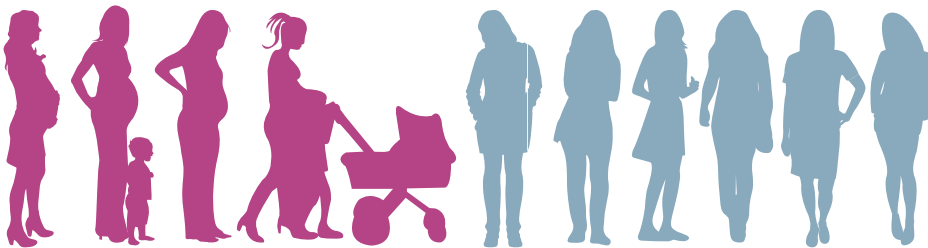
## THE ISSUE

Youth in the child welfare system are considered a high risk population for early pregnancy. What does this really mean?

- » **One-third of girls in foster care become pregnant at least once by age 17, and almost half become pregnant at least once by age 19.**



- » **A teen girl in foster care is 2.5 times more likely to become pregnant by age 19 than her adolescent peers who are not in foster care. Four in 10 girls in foster care also experience two or more pregnancies by age 19.**



### WHY IS THIS IMPORTANT?

- » Compared to women who delay childbearing, teen mothers are more likely to drop out of school and live in poverty.
- » The children of teen mothers in foster care are more likely to experience child abuse and neglect, and enter the child welfare system.



## THE CHECKLIST

This checklist can be used to help the youth you serve to make sound decisions about their sexual behavior and relationships; you can and should tailor it depending on the specific services and programs available in your jurisdiction. Complete this checklist for each youth you support. Some items will require you to have a conversation with the youth; follow the tips included later in this resource to get started.

PROMOTING HEALTHY YOUTH CHECKLIST	YES	NO	RESOURCES
Describe the youth's medical home. If the youth does not have a medical home, explain why not.	<input type="checkbox"/>	<input type="checkbox"/>	Identify a health care provider in the youth's community. If one is not readily available, consult the web-based resources to help find a clinic on page 30.
Is the youth familiar with birth control? If so, which methods does he or she recognize/ know about? Has the youth decided what method is best for them?	<input type="checkbox"/>	<input type="checkbox"/>	Talk with the youth about birth control and ensure they have access to a provider who can talk with them, too. See resources on pages 13–14 and 30 for more information.
What current, accurate information on preventing pregnancy and sexually transmitted infections (STI) does the youth have? From what source did the youth get the information?	<input type="checkbox"/>	<input type="checkbox"/>	Help youth to find a local program or resource that is current and accurate. Introduce youth to resources on the web. See pages 13–14 and 30 for more information.
How do you know that the youth is comfortable communicating his or her needs to a health care provider?	<input type="checkbox"/>	<input type="checkbox"/>	Talk to the youth about how to advocate for themselves when seeking health services. If youth is not comfortable, refer him or her to web resources for more support (see page 30). Consider incorporating reproductive health into Life Skills/Independent Living/ or other case services.

# TALKING WITH YOUTH

Working with young people means listening to them, allowing them to discuss concerns, and answering their questions. Here are a couple of things to keep in mind when you get questions from or have conversations with foster youth.

## QUESTIONS ABOUT SEXUAL IDENTITY

- » Ensure that you provide a supportive, non-judgmental environment. Cultural sensitivity is important when building a rapport with youth so that they are comfortable discussing sensitive and personal topics. Data suggest that lesbian, gay, bisexual, and transgender (LGBT) youth are overrepresented in the foster care population and experience higher rates of unplanned pregnancy than the general population, so it's important for you to be prepared to discuss the topic.
- » Use a value-neutral approach. That is, exclude your personal views from the discussion and focus on fact-based prevention messages (e.g., condoms reduce your risk for pregnancy and HIV). If you are not comfortable with your knowledge level, refer the youth to another trusted adult in their lives such as a family doctor, community worker, school counselor, or church member.

## QUESTIONS ABOUT SEX AND BIRTH CONTROL

- » Be sure youth know their rights. In particular, they should understand rights about consent for contraceptive services. For instance, in many states all minors may consent to contraceptive services. In most states Medicaid covers ALL forms of contraception, and Title X funding ensures access to confidential reproductive health services for teens. For more information see *Rights of Minors in Foster Care* on page 31.
- » Refer youth to digital resources for information about sexuality and birth control such as **StayTeen.org** (website for teens age 13–17) and **Bedsider.org** (website for young people age 18–29).

## QUESTIONS ABOUT PREGNANCY

- » Address the motivations that youth in foster care may have for getting pregnant. For example, a foster youth may see having a child as a way to give a child the love and care they feel they didn't have. Some youth may see having a child as a way to create the family they did not have or fill an emotional void. To some foster teens, having a child may mean not being alone, being loved, and having someone to love.
- » Try to engage the youth about these motivations for starting a family. Acknowledge that it is normal to want a stable, loving family. Then ask the youth to consider what the consequences of having a family now might be. Reinforce that the desire to start a family now relates to other important goals, such as getting an education, choosing a career, and being able to support a family. You might ask the youth:
  - › How will you support a child?
  - › What support systems do you have in place to help you raise a child?
  - › How will you attend college or acquire the skills needed to obtain a well-paying job if you are a parent now?
  - › How will you afford an apartment? Childcare? Groceries? Transportation?
- » Pregnancy may be used to control the youth if she is involved in an abusive relationship. Youth in abusive relationships may not be able to negotiate sexual activity or birth control with their partner leaving them at risk for pregnancy and/or STIs. Sometimes abusers can sabotage birth control as another means of control. Consider that the youth may feel as if pregnancy prevention is out of their control. You might ask the youth about their relationship (see below) as well as their access to and use of birth control. In addition, you may talk to youth who may be facing birth control sabotage, about methods of birth control that are not partner reliant and can't be seen by partners like IUDs, the implant, and the shot.

## QUESTIONS ABOUT RELATIONSHIPS

- » Foster youth may be more vulnerable to early pregnancy because they are at greater risk for engaging in sex and unprotected sex during their teen years. Foster youth may decide to have sex because of a close relationship with a boyfriend or girlfriend. Youth who become sexually active may forego the use of birth control in response to a partner's desire to have unprotected sex. Youth also may be less careful about birth control because they are in a relationship or are indifferent to pregnancy or wish to get pregnant.
- » Youth may face enormous pressure from society, friends, and significant others to have sex. Empower them to negotiate relationships and sexual activity in their relationships by teaching them strong communication skills. Provide them with the tools to anticipate pressure and respond appropriately. Help them to understand when pressure becomes coercive or abusive and the confidence to leave a relationship that doesn't match their expectations.
- » Acknowledge that it is normal for someone to want stable relationships. Discuss the attributes of healthy versus unhealthy relationships and the warning signs of an abusive relationship. Healthy relationships do not involve pressure to have sex or pressure to have unprotected sex. Healthy relationships support the desire to pursue educational, career, and personal goals.
- » Engage the youth in activities helping them to identify healthy vs unhealthy behaviors in relationships. Consider using the Relationship Spectrum from [LoveIsRespect.org](http://LoveIsRespect.org).

## TYPES OF QUESTIONS

When faced with a tricky question it may be helpful to first identify what type of question you are dealing with and then determine an appropriate response.

Here are some common types of questions you may encounter from the youth you support:

### QUESTION TYPE INFORMATION-SEEKING

#### DEFINITION

Straightforward questions with specific, factual answers.

#### SAMPLE QUESTION

Can you get an STI from a toilet seat?

#### SAMPLE RESPONSE

Since most STIs are caused by germs and bacteria that are very fragile, it is not possible to get a disease from a toilet seat because the bacteria or virus could not stay alive there. (Note: take this opportunity to share additional information on how STIs are transmitted and where to get tested)

### QUESTION TYPE AM I NORMAL?

#### DEFINITION

These questions are often about something a person worries about and needs reassurance on. So while there may be a factual response, the person needs to know that wanting to know the answer is normal.

#### SAMPLE QUESTION

Why are boys horny all the time?

#### SAMPLE RESPONSE

It really does seem as though all boys are horny all the time, but we know that not only are some boys not at all interested in sex, but many girls can be very interested in sex and we don't often hear about that. It is really normal for teens to think about sex a lot, be curious, and even masturbate a lot. It is also normal for those feelings not to be very strong at all. People develop at different rates and so a person's interest in sex is a really individual thing. Why do you think we have this stereotype that all guys are horny?

**QUESTION TYPE****PERSONAL BELIEF****DEFINITION**

These questions are a test of how much you are willing to share about yourself. Most of the time, sharing personal information is not appropriate, but generally explaining to the youth that your experiences happened at a time very different from today, and therefore are not relevant to them, is a safe way to avoid answering these types of questions.

**SAMPLE QUESTION**

How old were you when you had sex for the first time?

**SAMPLE RESPONSE**

Since I am not you it would not be helpful to you for me to give you an answer. We can talk together about the choice you have to make, and then maybe it will be easier for you to make a decision that is right for you.

**QUESTION TYPE****SHOCK QUESTIONS****DEFINITION**

These questions are asked to test you. This is a check of your sense of humor, your ability to think on your feet, and your ability to not get flustered or upset by a question. Sometimes it is best to ignore the question, but other times, it helps to give a serious answer.

**SAMPLE QUESTION**

My girlfriend smells like dead stinky fish, what should I do?

**SAMPLE RESPONSE**

This question is asking about something we often hear—that a girl's vagina smells dirty or bad, but the way it is asked is part of the problem. It is true that many vaginas have a scent and that some are stronger and more noticeable than others. This is very normal. It is not right to make a girl or woman feel bad about her body especially over something completely normal. However, if the smell is different than usual, it could be a sign of infection and she should see a doctor.

# RESOURCES

## FIND A LOCAL HEALTH CENTER

### **StayTeen.org**

Enter your zip code in the health center finder at **StayTeen.org/health-centers**

### **Bedsider.org**

Enter your zip code in the location box at **Bedsider.org/where\_to\_get\_it** or  
TEXT MYBC to 42411

## HAVE QUESTIONS ABOUT SEX & BIRTH CONTROL?

**Bedsider.org** (website for young people age 18-29)

**StayTeen.org** (website for teens age13-17)

**GoAskAlice.Columbia.edu**

**SexEtc.org**

## BIRTH CONTROL METHODS

*Pocket Protector: A Guide to Birth Control Options* (available on **TheNationalCampaign.org**)

**Bedsider.org** (website for young people age 18-29)

**StayTeen.org** (website for teens age13-17)



# RIGHTS OF MINORS IN FOSTER CARE



# RIGHTS OF MINORS IN FOSTER CARE

The reproductive health rights of youth in foster care are no different than those of their peers outside of the foster care system. In many states minors have the right of access to free or low-cost confidential reproductive health care, including youth in foster care. In most states Medicaid covers many, if not all forms of contraception and most minors in foster care are already accessing Medicaid services for their general health care coverage. As reproductive health is part of the foster youth's overall safety, wellbeing, and permanency, it is important that judges understand foster youths' rights and hold stakeholders accountable for providing access to reproductive health information and care.

Many foster care system stakeholders are unfamiliar with the reproductive health rights of youth in foster care, and some may even believe policies exist in their organization against discussing and providing access to reproductive health care for foster youth. Not so. Consider the following:

- » No state limits or prohibits discussion of reproductive health options with foster youth. If a stakeholder claims that a policy exists prohibiting discussion of reproductive health options with foster youth, judges should ask for a copy of the "policy" which restricts discussion so that the court can fully understand the restriction.
- » No state explicitly requires parental consent or notification for contraceptive services. However, two states (Texas and Utah) require parental consent for contraceptive services paid for with state funds.<sup>1</sup>
- » Twenty-one states and the District of Columbia explicitly allow minors to obtain contraceptive services without a parent's involvement. Another 25 states have affirmed that right for certain classes of minors, while four states have no law.<sup>1</sup> In the absence of a specific law, courts have determined that minors' privacy rights include the right to obtain contraceptive services. For more information visit the Guttmacher Institute's State Policy Brief on Minor's Access To Contraceptive Services.<sup>1</sup>

## SAMPLE GUIDE TO THE RIGHTS OF MINORS IN FOSTER CARE

- » Foster Youth Have Rights.  
This website, <http://www.fosteryouthhelp.ca.gov/rights2.html>, from the California Ombudsman for Foster Care is specifically for foster care youth. It details health, school, and family rights as well as rights within the foster care home and the court room.

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<sup>1</sup> Guttmacher Institute. (October 2014). State Policies in Brief: Minors' Access to Contraceptive Services. Retrieved October 17, 2014 from [http://www.guttmacher.org/statecenter/spibs/spib\\_MACS.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf).







# SAMPLE SCRIPTS



# SAMPLE SCRIPTS

Judges don't have to talk to foster youth about sex or discuss a youth's personal decisions in open court, however you do need to make sure the conversations are happening as part of your oversight of the youth's health and wellbeing. In other words, your role as a judge is not to become a "sexpert" or act as a sex educator within your courtroom, but instead to hold accountable those stakeholders responsible for the youth's safety, wellbeing, and permanency. This also includes ensuring that youth in care are receiving appropriate and reliable information and clinical services; that there are caring, healthy, adult relationships supporting the youth; and that the youth are motivated by future plans beyond foster care. These three elements are key in preventing teen and unplanned pregnancy. Here are some suggestions for getting the conversation started; whether you ask stakeholders or the youth themselves, the answers will help you guide, direct, and hold stakeholders accountable.

## ON THE TOPIC OF RELATIONSHIPS AND IDENTIFYING A CARING ADULT

### FOR YOUTH

It sounds like you have a lot going on in your life right now with balancing school, work, and a social life—who do you talk to when you need to talk about what's going on in your life?

### FOR STAKEHOLDERS

Who is the caring adult in the foster youth's life to talk to and provide support?

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### FOR YOUTH

When you have a question about something going on in your life, who is the first person you think of asking? Who else might you ask if you can't get ahold of that person?

### FOR STAKEHOLDERS

Who is the caring adult in the foster youth's life to talk to and provide support?

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### FOR YOUTH

You've mentioned that you have a boyfriend/ girlfriend/ partner—when you need some relationship advice, who can you turn to for answers? Are there any others in your life (or on your treatment team) you could talk to?

### FOR STAKEHOLDERS

Who is the caring adult in the foster youth's life to talk to and provide support?

**FOR YOUTH**

It sounds like you have made some plans for your future with your treatment team like college, working, and living on your own. Have you considered how having a baby right now might impact those plans? Have you learned what to do to delay a pregnancy until you are ready to be a successful parent?

**FOR STAKEHOLDERS**

What plans has the youth made for the future? What has been discussed about how the youth can delay pregnancy until they are ready? Does the youth understand that “being ready” is more than simply wanting a child?

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**FOR YOUTH**

As you become an adult, taking care of your health needs on your own is important. Has your social worker discussed how to make a doctor’s appointment? If you need some suggestions about what to say when you call to make an appointment, check out [StayTeen.org](http://StayTeen.org) (a website for teens age 13–17) or [Bedsider.org](http://Bedsider.org) (a website for young people age 18–29).

**FOR STAKEHOLDERS**

Who has discussed with the youth how to make a doctor’s appointment? Who has assisted the youth with what to say when they call for an appointment?

**FOR YOUTH**

It sounds like you have a dental appointment, a counseling appointment, and a vision appointment coming up. Has your social worker also planned a visit to the clinic to have sexual health screening done? Like the dentist, counselor, and eye doctor, this is part of everyone’s basic health care and should be done on a regular basis.

**FOR STAKEHOLDERS**

When is the youth scheduled to visit a clinic for a sexual health screening?

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### FOR YOUTH

Is it easy to go see your doctor? Does your doctor talk to you about things like birth control? (If not, request that the social worker to follow up with medical staff)

### FOR STAKEHOLDERS

Who is ensuring that the doctor has talked with the youth about birth control?

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### FOR YOUTH

If you or your partner has questions about your relationship or about sex, where do you go to get answers? Is there someone on your team you can talk to about these questions? Have you discussed these topics with your regular doctor?\*

### FOR STAKEHOLDERS

Describe how you have communicated to the youth who on the team is available to talk about relationships and sex.

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### FOR YOUTH

Have you had a class on sex ed at your school? Was the teacher helpful and did they cover where to go to get birth control or condoms for free?

### FOR STAKEHOLDERS

When did the youth attend a class on sex ed and when? How does the youth know where to get birth control and condoms for free and without embarrassment?

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\* Suggest visiting [StayTeen.org](http://StayTeen.org) (for teens age 13–17) or [Bedsider.org](http://Bedsider.org) (for young people age 18–19) for more information about relationships, birth control, and a zip code-based clinic locator. These website referrals can even be part of a handout given to the youth at the hearing.





# 7 THINGS YOU CAN DO TO HELP PREVENT PREGNANCY AMONG YOUTH IN FOSTER CARE





# 7 THINGS YOU CAN DO TO HELP PREVENT PREGNANCY AMONG YOUTH IN FOSTER CARE

## 1 STOCK USEFUL RESOURCES IN YOUR COURTROOM.

No need for a lengthy conversation, or for you to brush up on your knowledge of birth control options. You can provide young people with access to information that can help them to better plan for their futures by simply making medically accurate, youth-friendly resources available in your courtroom. Take a look at The National Campaign's *Pocket Protector: A Guide to Birth Control Options* and the Birth Control Method Explorers available at [StayTeen.org](http://StayTeen.org) or [Bedsider.org](http://Bedsider.org).

## 2 DISPEL MYTHS.

If a discussion about the rights of youth in care comes up, be clear that youth in foster care have the same ability to consent to reproductive health services (including sexually transmitted infection screening and ALL contraceptive options) as youth who are not in care. Often confusion about a youth's rights to access to care can lead support staff to inaction and concerns about "policy" and "rules" that may not actually exist. (See *Rights of Minors in Foster Care* on page 31.)

## 3 ASK ABOUT ALL OF A YOUNG PERSON'S HEALTH CARE NEEDS.

A youth's sexual health is part of their overall health. When inquiring about the health care needs of a youth in your courtroom don't stop at dental, vision, and appropriate mental health needs—ask if appointments have been made for sexual health services as well. These appointments might include screenings for sexually transmitted infections (STIs) as well as birth control, but there's no need to go into detail; simply remind social workers or guardians ad litem to make these appointments as part of a youth's routine overall health care.

## 4 TREAT YOUTH IN CARE LIKE THEY ARE EXPERTS... BECAUSE THEY ARE!

Youth are experts on themselves. If we take the time to have conversations with them about the relationships in their lives we can learn a lot about their needs and whether or not they are being met. (See the *Sample Scripts* on page 33 for more ideas about getting the conversation started.)

## 5 HARNESS THE POWER OF PARENTS AND PARENT FIGURES.

Parents have power and influence. In fact, youth report that they want to hear messages about sex and relationships from their parents or the parent figures in their lives, and this includes foster parents. Provide resources in your courtroom for parents, foster parents, or the healthy adult relationship in the youth's life so that adults can discuss this issue in their homes, and encourage conversations by asking youth about the topic during routine permanency hearings. (See The National Campaign's parent resources *Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy and Talking Back: What Teens Want Adults to Know About Teen Pregnancy* available on [TheNationalCampaign.org](http://TheNationalCampaign.org) for more information on engaging parents.) Coordinate with social services and the youth's Court Appointed Special Advocate (CASA) so that the resources provided to parents, foster parents, and the healthy adult relationship in the youth's life in the courtroom are the same as those used by stakeholders.

## 6 ASK ABOUT RELATIONSHIPS WITH CARING ADULTS.

Qualitative data suggest that youth in care are less motivated than youth in the general population to avoid pregnancy and in fact many might be interested in becoming pregnant. Interest in having a baby might be driven by a desire for permanent and stable relationships. Ensuring that youth in care have a stable and caring adult in their lives might help reduce this motivation.

## 7 ENCOURAGE YOUTH IN CARE TO THINK ABOUT AND PLAN FOR THEIR FUTURE.

Youth who believe they have a successful future ahead of them are more likely to delay sex, pregnancy, and parenthood. Work with youth to explore educational and other life goals, how to achieve those goals, and how decisions made now might impact whether or not they achieve those goals.





The National Campaign to Prevent Teen and Unplanned Pregnancy  
202.478.8500 • [www.TheNationalCampaign.org](http://www.TheNationalCampaign.org) • [www.Bedsider.org](http://www.Bedsider.org) • [www.StayTeen.org](http://www.StayTeen.org)

## Reproductive and Sexual Health Care Rights Findings for Foster Youth and NMD

**Rule 5.708: Court finds that the agency has developed the case plan and the case plan meets the requirements of Welf. & Inst. Code §16501.1, including that the Social Worker or Probation Officer has:**

- Informed the youth in a manner appropriate to the age or developmental level of the youth of their rights at least once every six months;
- Informed the Care Providers (foster parents, group home) that the care provider is responsible for ensuring that adolescents, including NMDS, receive age-appropriate, medically accurate, culturally sensitive pregnancy prevention information, and

*For youth 10 years of age and older:*



- The youth has been provided access to age appropriate, medically accurate information about sexual development, reproductive and sexual health care, prevention of unplanned pregnancies, abstinence, use of birth control, abortion, and the prevention and treatment of STIs,
- The case plan has been updated annually to address provision of sexual health education;
- The case plan has been updated annually to confirm facilitated access to care, including addressing any barriers to care, as needed.

**Questions for the Court to ask:** Who is the trusted adult in the youth's life? Have barriers been addressed?

**Foster youth and NMDS have the following rights (Welf. & Inst. Code §§ 369, 16501.1, 16001.9, 16521.5, Fam. Code §§ 6925, 6926, 6928)**

- To receive medical services, including reproductive and sexual health care
- To consent to or decline medical care (without need for consent from a parent, caregiver, guardian, social worker, probation officer, court, or authorized representative) for:
  - The prevention or treatment of pregnancy, including contraception, at any age (except sterilization)
  - An abortion, at any age.
  - Diagnosis and treatment of sexual assault, at any age.
  - The prevention, diagnosis, and treatment of STIs, at age 12 or older.
- To access to age-appropriate, medically accurate information about reproductive and sexual health care, the prevention of unplanned pregnancy including abstinence and contraception, abortion care, pregnancy services, and the prevention, diagnosis, and treatment of STIs, including but not limited to the availability of the Human Papillomavirus (HPV) vaccination.
- To be provided transportation to reproductive and sexual health-related services. Many reproductive health services are time-sensitive (e.g. emergency contraception, abortion); therefore, transportation **must be provided** in a timely manner in order to meet the requirement.
- To obtain, possess and use the contraception of his or her choice, including condoms.
- To have private storage space and be free from unreasonable searches of his or her personal belongings. Contraception **cannot** be taken away as part of a group home discipline program or for religious beliefs, personal biases and judgments of another person.
- To choose his or her own health care provider, if payment for the health service is authorized under applicable Medicaid law.
- To fair and equal access to all available services, placement, care, treatment and benefits, and to not be subjected to discrimination or harassment based on actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.
- To independent contact with state agencies regarding violations of rights, to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints.
- Personal rights are to be posted and/or explained in an age or developmentally appropriate manner and provided to the foster youth or NMD.

## Duties and Responsibilities Delivering Sexual and Reproductive Health Services and Information to Foster Youth

Rights of Foster Youth		Case Worker Obligations (County social workers and probation officers)	Caregiver Obligations (Foster care providers)
 <p><b>Foster youth shall be provided information and informed of...</b></p>	<p>Youth have the right to receive medically accurate, age appropriate sexual and reproductive <u>information</u> at all ages<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall provide youth and NMDs with a copy of the Foster Youth Rights upon entry into foster care and at least once every six months at the time of scheduled contact.”<sup>2</sup></li> <li>• “The case management worker (social worker or probation officer) shall provide youth and NMDs with access to age-appropriate, medically accurate information about reproductive and sexual health care, unplanned pregnancy prevention, abstinence, use of birth control, abortion and the prevention and treatment of STIs”<sup>2</sup></li> <li>• “County agencies shall provide youth and NMDs with educational materials regarding the prevention of unplanned pregnancy and STI’s that are medically accurate, age and developmentally appropriate, trauma-informed, strengths-based, and whenever possible, evidenced-based.”<sup>2</sup></li> <li>• “For a youth in foster care 10 years of age or older who is in junior high, middle, or high school, or a nonminor dependent enrolled in high school, the case plan shall be reviewed annually, and updated as needed, to indicate that the case management worker has verified that the youth or nonminor dependent received comprehensive sexual health education that meets the requirements established in Chapter 5.6 (commencing with Section 51930)...” at least once in middle school and at least once in high school. See WIC 16501.1(g)(20).<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers, in consultation with the case management worker (county social worker or probation officer), shall ensure that youth and NMDs who remain in long-term foster care receive age-appropriate, medically accurate, culturally sensitive pregnancy prevention information.”<sup>2</sup></li> <li>• “Depending on the type of licensed home or facility and age of the foster youth, personal rights are to be posted and/or explained in an age or developmentally appropriate manner, and provided to the foster youth.”<sup>1</sup></li> </ul>
	<p>Youth must be informed of rights, including consent rights as described in ACL 16-82<sup>2</sup></p>	<ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall provide youth and NMDs with a copy of the Foster Youth Rights upon entry into foster care and at least once every six months at the time of scheduled contact.”<sup>2</sup></li> <li>• “The case management worker (social worker or probation officer) shall inform youth, in an age appropriate manner, of their rights to</li> </ul>	



1 CDSS All-County Letter 16-82, “Reproductive and Sexual Health Care and Related Rights for Youth and NMDs in Foster Care” (2016)

2 CDSS All-County Letter 16-88, “California’s Plan for the Prevention of Unintended Pregnancy for Youth and NMDS in Foster Care”(2016)

3 Welfare and Institutions Code 16501.1(g)(20), (21).

4 CDSS “A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention” (Sept. 2017)

## Duties and Responsibilities Delivering Sexual and Reproductive Health Services and Information to Foster Youth

		<p>consent at any age to pregnancy-related care, including contraception, abortion, and prenatal care.”<sup>2</sup></p> <ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall inform youth of their right to consent at age 12 or older to the prevention, diagnosis and treatment of STIs.”<sup>2</sup></li> </ul>	
	<p>Youth must be informed of confidentiality rights as described in ACL 16-82<sup>2</sup></p>	<ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall inform youth and NMDs about their confidentiality rights regarding medical services and seek the youth’s and NMD’s written consent prior to any disclosure of their sexual or reproductive health information.”<sup>2</sup></li> <li>• “The case management worker (social worker or probation officer) shall inform youth and NMDs of their right to withhold consent to such disclosure(s).”<sup>2</sup></li> </ul>	
 <p><b>The right to neutral, non-biased information and care and support for healthy sexual development</b></p>	<p>Foster youth have the right to fair and equal access to all available services, placement, care, treatment and benefits, and to not be subjected to discrimination or harassment based on actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or Human Immunodeficiency Virus (HIV) status.<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall not impose their personal biases and/or religious beliefs upon the youth and NMD.”<sup>2</sup></li> <li>• “County agencies shall use the reasonable and prudent parent standard to create normalcy and to support the healthy sexual development of youth and NMDs based on their individual needs.”<sup>2</sup></li> <li>• “County agencies should use culturally-inclusive, trauma-informed, strengths-based, and whenever possible, evidence-based practices and programs.”<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers should support the healthy sexual development of youth and NMDs and shall not impose their personal biases, judgments and/or religious beliefs.”<sup>2</sup></li> <li>• “Providers shall incorporate the reasonable and prudent parent standard<sup>1</sup> to create normalcy for the youth and NMD.”<sup>2</sup></li> <li>• “Providers should cultivate an open, honest and supportive environment where youth and NMDs feel comfortable to talk about sensitive issues such as sex, abstinence, abortion, contraceptive use, STIs, reproductive and sexual health and</li> </ul>

1 CDSS All-County Letter 16-82, “Reproductive and Sexual Health Care and Related Rights for Youth and NMDs in Foster Care” (2016)




2 CDSS All-County Letter 16-88, “California’s Plan for the Prevention of Unintended Pregnancy for Youth and NMDS in Foster Care”(2016)

3 Welfare and Institutions Code 16501.1(g)(20), (21).

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## Duties and Responsibilities Delivering Sexual and Reproductive Health Services and Information to Foster Youth

			SOGIE [sexual orientation, gender identity, and gender expression].” <sup>2</sup>
 <p><b>Access to Care</b></p>	<p><b>Facilitating access to sexual and reproductive health provider of choice</b></p> <p>Youth have the right to receive medical services, including reproductive and sexual health care.<sup>1</sup></p> <p>Youth have the right to choose their own sexual health care provider, if payment for the health service is authorized under applicable Medicaid law.<sup>1</sup></p> <p>Youth have the right to obtain, possess and use the contraception of their choice, including condoms<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• “The case management worker (social worker or probation officer) shall ensure youth are up-to-date on their annual medical appointments.”<sup>2</sup></li> <li>• The case management worker (social worker or probation officer), shall ask the youth and NMD if they are facing any barriers in accessing reproductive and sexual health care services or treatment, and shall ensure any barriers are addressed in a timely manner. The case management worker can get the information directly from the youth or NMD, or in some instances may learn about it from the foster care provider.<sup>2</sup></li> <li>• “<u>Before</u> receiving reproductive or sexual health information from a youth, case managers should explain to youth that the information they share <u>will remain confidential</u> unless:             <ul style="list-style-type: none"> <li>• The youth consents to disclosure or</li> <li>• there is a potential safety issue”<sup>4</sup></li> </ul> </li> <li>• “For a youth in foster care 10 years of age or older or a nonminor dependent, the case plan shall be updated annually to indicate that the case management worker has... Informed the youth or nonminor dependent how to access reproductive and sexual health care services and <u>facilitated access to that care</u>, including by assisting with any identified barriers to care, as needed.”<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers shall ensure that youth and NMDs receive an annual medical exam as required by the new “Child Health and Disability Prevention Program Bright Futures Periodicity Schedule for Health Assessments by Age Groups” schedule.”<sup>2</sup></li> <li>• “Providers shall facilitate access and transportation to reproductive and sexual health related services unless otherwise arranged.”<sup>2</sup></li> <li>• “Providers shall respect the private storage space and personal belongings of the youth and NMD as it relates to their reproductive and sexual health care.”<sup>2</sup></li> </ul>
 	<p>Youth have the right to be provided <u>transportation</u> to reproductive and sexual health related services.<sup>1</sup></p> <p>Transportation must be provided in a timely manner.<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• The case management worker (social worker or probation officer) shall ask the youth and NMD if they are facing any barriers in accessing reproductive and sexual health care services or treatment, and shall ensure any barriers are addressed in a timely manner.”<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers shall facilitate access and transportation to reproductive and sexual health related services unless otherwise arranged.”<sup>2</sup></li> </ul>




1 CDSS All-County Letter 16-82, “Reproductive and Sexual Health Care and Related Rights for Youth and NMDs in Foster Care” (2016)

2 CDSS All-County Letter 16-88, “California’s Plan for the Prevention of Unintended Pregnancy for Youth and NMDS in Foster Care”(2016)

3 Welfare and Institutions Code 16501.1(g)(20), (21).

4 CDSS “A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention” (Sept. 2017)

## Duties and Responsibilities Delivering Sexual and Reproductive Health Services and Information to Foster Youth

	<p><b>Addressing barriers to care</b></p>	<ul style="list-style-type: none"> <li>• The case management worker (social worker or probation officer) shall ask the youth and NMD if they are facing any barriers in accessing reproductive and sexual health care services or treatment, and shall ensure any barriers are addressed in a timely manner.<sup>2</sup></li> <li>• “For a youth in foster care 10 years of age or older or a nonminor dependent, the case plan shall be updated annually to indicate that the case management worker has... Informed the youth or nonminor dependent how to access reproductive and sexual health care services and <u>facilitated access to that care</u>, including by assisting with any identified barriers to care, as needed.”<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers shall notify the case management worker (county social worker or probation officer) of any barriers the youth or NMD experiences in accessing reproductive and sexual health care services or treatments.”<sup>2</sup></li> </ul>
 <p>Document- ation</p> 	<p><b>Documenting the above requirements</b></p>	<p>For youth and NMDs 10 and older, case management workers must document in the case plan annually:</p> <ul style="list-style-type: none"> <li>• That worker has informed the youth or young adult             <ul style="list-style-type: none"> <li>○ that he or she may <u>access information</u> about reproductive and sexual health care.</li> <li>○ in an age- and developmentally appropriate manner, of his or her <u>right to consent</u> and <u>confidentiality rights</u> regarding those services.</li> <li>○ <u>how to access</u> reproductive and sexual health care services</li> </ul> </li> <li>• That worker has <u>facilitated access</u> to that care, including by assisting with any identified barriers to care, as needed</li> <li>• For youth in middle or high school, that youth has <u>received sexual health education</u> at least once in middle school and at least once in high school or how the county will ensure the youth receives the education.<sup>3</sup></li> </ul> <p>“The case management worker (social worker or probation officer) should document the youth’s and NMD’s reproductive and sexual health care and services in a sensitive manner to ensure their privacy and compliance with federal and state confidentiality laws<sup>2</sup></p>	


1 CDSS All-County Letter 16-82, “Reproductive and Sexual Health Care and Related Rights for Youth and NMDs in Foster Care” (2016)

2 CDSS All-County Letter 16-88, “California’s Plan for the Prevention of Unintended Pregnancy for Youth and NMDS in Foster Care”(2016)

3 Welfare and Institutions Code 16501.1(g)(20), (21).

4 CDSS “A Guide for Case Managers: Assisting Foster Youth with Healthy Sexual Development and Pregnancy Prevention” (Sept. 2017)

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 <p><b>Storage, Confidentiality, and Privacy</b></p>	<p>Youth have the right to have <u>private storage space</u> and to be free from unreasonable searches of his or her personal belongings.<sup>1</sup></p> <p>Youth have the right to patient <u>confidentiality</u> regarding sexual and reproductive health services, unless there is written consent to disclosure or through court order.<sup>1</sup></p> <p>Youth have the right to <u>privacy for examination or treatment</u> by a medical provider for sexual and reproductive health care, unless the youth specifically requests otherwise.<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• <u>Before</u> receiving reproductive or sexual health information from a youth, case managers should explain to youth that the information they share <u>will remain confidential</u> unless:             <ul style="list-style-type: none"> <li>○ The youth consents to disclosure or</li> <li>○ there is a potential safety issue<sup>4</sup></li> </ul> </li> <li>• “The case management worker (social worker or probation officer) should document the youth’s and NMD’s reproductive and sexual health care and services in a sensitive manner to ensure their privacy and compliance with federal and state confidentiality laws<sup>2</sup></li> <li>• “The case management worker (social worker or probation officer) shall inform youth and NMDs about their confidentiality rights regarding medical services and seek the youth’s and NMD’s written consent prior to any disclosure of their sexual or reproductive health information.”<sup>2</sup></li> <li>• “The case management worker (social worker or probation officer) shall inform youth and NMDs of their right to withhold consent to such disclosure(s).”<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• “Providers shall respect the private storage space and personal belongings of the youth and NMD as it relates to their reproductive and sexual health care.”<sup>2</sup></li> </ul>
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## California Sexual and Reproductive Health Care Services

California has a network of laws, programs, and services designed to meet the sexual health care needs of adolescents. These include:

**Mandatory comprehensive sexual health education** in public middle and high schools

**Consent rights** that allow adolescents who need it to confidentially access care

A network of clinics that provide **sexual health services** to address adolescent needs

**Public funding streams** for sexual health services to ensure free access

**Trustworthy information** for teens and adult caregivers



In California, the availability of three different public funding programs means that **a full range of sexual and reproductive health services is available to adolescents at no cost.**

### Birth Control for Adolescents

- Public and private insurance must pay for **all methods of birth control**, including emergency contraception
- Birth control **must be free** (no co-pays!)
- Adolescents can request a **12-month supply** of pills, patches, and rings at one time
- **Free condoms** for adolescents through the Condom Access Project
  - Youth can request free condoms or find locations to pick them up at: [www.teensource.org/condoms/free](http://www.teensource.org/condoms/free)
- Minors **of all ages** have a right to consent to and to confidentiality in services.

### STI Screening and Services for Adolescents

- Most public and private insurance must pay for recommended screening and prevention with no co-pay, including the HPV and Hepatitis B vaccines.
- STI screening and services are available with no co-pays.
- **Free condoms** for adolescents through the Condom Access Project. Information at: <http://www.teensource.org/condoms/free>
- MediCal Minor Consent covers PrEP for minors with no co-pay. PrEP is a pre-exposure prophylactic medication that reduces the risk of HIV infection.
- Minors 12 and older have a right to consent to and to confidentiality in services.

### Pregnancy Testing, Prenatal Care and Abortion for Adolescents

- Testing and services with no co-pay
- MediCal covers prenatal, postnatal, abortion and related services, such as ultrasound, with no co-pay.
- Insurance must ensure timely access to providers.
- Minors **of all ages** have a right to consent to and to confidentiality in services.

**Teens can find sexual and reproductive health clinic referrals, including referrals for no-cost care at:**

<http://www.teensource.org/find-a-clinic>

Sources: NHeLP, *Reproductive Coverage in Medi-Cal*, at <http://www.healthlaw.org/storage/documents/NHeLP-ReproHC-MediCal-Web-F.pdf>; Access and NHeLP, *California Abortion Coverage in MediCal and Private Insurance*, at <http://accesswhj.org/sites/default/files/docs/NHeLP-CAAbortionCoverageFactSheet-Web.pdf>; KFF, *Payment and Coverage for the Prevention of Sexually Transmitted Infections*, at <https://www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-stis>

## Case Scenario

In working through the following case scenario, keep in mind the following considerations:

- What are the greatest potential risks to healthy development for this youth that should be considered by the courts, lawyers, and the responsible agency?
- What is necessary for the court, agency, lawyers, and other court stakeholders to consider building a youth's resiliency?

### **Part I:**

Andrew (14), Bonnie (11), and Charli (5) were removed from the custody of their biological mother due to mother's substance use, domestic violence in the home, and her difficulties managing her own mental well-being. The detention report indicates that Andrew is currently expelled from school. Andrew has been cited 4 times by the school resource officer for fighting and was found with marijuana and a knife in his backpack. He is currently on informal probation. The report also indicates there are no relatives available for placement. Andrew and Bonnie are placed in a resource family home that has one other (non-familial) teenager. Charli is placed in an emergency placement. The children live in the same county, but different cities. Mother states that the father of Andrew and Bonnie has not seen them in a few years. Mother says that her current boyfriend is the father of Charli.

At the **detention** hearing, in your role, what would you advocate for the court order by way of visitation, services, and placement (be specific)?

Visitation:

Services:

Placement:

What additional questions should the Court ask?

**What are the concrete actions the courts, agency, lawyers and court partners can take to engage and partner with the family (resource and birth) as valued and respected partners?**

## Case Scenario

### **Part II:**

At the 12-month review, the report indicates that mother has been clean and sober for about 10 months. She is having unsupervised visits with Charli and Bonnie. Andrew has not done well. He was arrested for drug and gun possession and assault on an officer. A 602 petition was filed and Andrew was found to be a ward of the court. Andrew is placed in a STRTP out of county. Andrew has been in some fights at the group home and recently destroyed property.

Mother and the Resource Parents have been working okay together. Mother is frustrated because she feels like she has done everything and wants Charli and Bonnie returned. Bonnie and Andrew's father has been consistent in visiting. A paternal aunt has been in communication with the child welfare department. The department is recommending continued services for all Bonnie and Charlie.

Placement – Where should the children live?

- What should be considered in deciding where the children should live?
- If Charli and Bonnie go home, what should the process be?
- If the Charli and Bonnie do go home to mom, what happens with the Resource Parents?
- What occurs with Andrew? What are the obligations of the probation department?

Reproductive Rights

- What documentation regarding sexual and reproductive health education, information or services should be in Andrew's case plan? In Bonnie's?
- In your role, what responsibility, if any, do you have in ensuring Andrew and Bonnie receive age appropriate, inclusive and accurate sexual health education?