Supporting the Healthy Sexual Development of Youth

Marymichael Smrdeli: Welcome everyone, to the "Supporting the Healthy Sexual Development of Youth" webinar. This webinar is hosted through the Judicial Council of California and the LA RHEP for Foster Youth, which is a public-private partnership in Los Angeles. Today we're going to be talking about the healthful, healthy sexual development of youth in foster care.

Our presenters today are: Rebecca Gudeman, she's a Senior Director of Health for the National Center for Youth Law. Luciana Svidler, she is the Policy Associate for the California Law Center, Children's Law Center of California. And me, I am Marymichael Smrdeli, I'm an attorney for the Center for Families, Children & the Courts at the Judicial Council of California.

Our intended audience for this webinar is specifically to attorneys and judges practicing in the child welfare and juvenile justice court system. So specifically, those attorneys and judges dealing with youth in foster care. This subject, as we'll talk about throughout this 90-minute session, will have a lot of information for probation and child welfare workers as well, but the intended audience is actually for judges and attorneys.

The child welfare and probation subjects will be dealt with in a separate training plan that is being developed through the California Department of Social Services. They are currently contracting with an organization called CalSWEC to create a curriculum for social workers and probation officers. So, although we would love social workers and probation officers to listen to this webinar and gain any insight that they can, this particular webinar is for judges and attorneys and those in the legal community. However, all the information will be pertinent to anyone who decides to listen.

Our learning objectives today are to: identify the rights of youth and nonminor dependents in foster care to their sexual and reproductive health care and information; to explain the laws and privileged information regarding this topic; to describe the duties and responsibilities of the caseworkers in ensuring that foster youth and nonminor dependents can obtain sexual and reproductive health information; and to demonstrate your role, such as the attorney or judge, in engaging youth and nonminor dependents about healthy sexual development for youth in foster care.

The agenda for today's talk is really starting out with the why. Why are we talking about healthy sexual development for youth in foster care? Accessing age-appropriate sexual health information for children in foster care. How to document in the case plan and the court reports, this information. The confidentiality and privileged laws that go along with it. As well as the roles that the attorneys and judges play when discussing this topic. And finally, we will wrap it all up with some case scenarios in hopes to give you some practical application about how this might, how these topics may occur in your cases. And some of these fact patterns (3:04) that you have probably are familiar with and have seen in your daily practice as judges and attorneys.

So now, I am going to turn it over to Rebecca, and I will let her give more introduction if she wants and talk to you about sexual health development. So, Rebecca…

Rebecca Gudeman: Alright, thank you. Thank you, Marymichael.

Yeah, so I'm going to start us off with a little context and why. Not everyone asks this, but we certainly do hear, "Hm, should we really be talking about sexual development with youth in foster care?" Some folks wonder if this is really the role that they might have, you know, maybe this is something best left to the biological parents. Some folks wonder whether this is perhaps encouraging youth to engage in sexual activity if we talk to them about it. There's a lot of really good questions and reasons why folks may hesitate to talk about sexual development with youth in care. But my ultimate answer to this question is: yes, we should.

And I'm going to share with you three reasons. We have lots of science and psychology research that we could cover that, that identify why it's so important to give young people a grounding in these issues. And if you are a parent or you know a parent or a caregiver, you'll know that you like it or not, these are questions that come up and indeed on the, on this slide you'll see some book covers. If you go to Amazon, you'll find over 4,000 books available for parents to try to help them navigate these kinds of questions. But today I'd like to cover just three re-, very *practical* reasons why these, this is a topic that we all need to know about if we work in, in foster care and child welfare.

So first, is the Reasonable and Prudent Parent Standard. This is still relatively new for all of us, but what it, but what it does is really require us to focus on normalcy when we're looking at creating a, a caring environment and a placement for a young person. And that includes creating normal opportunities for development and growth.

So, what does "normal development" mean? It's really easy to appreciate the developmental role that after-school activities might play, like sports or additional tutoring or chess club.

But what about these kinds of after-school activities? Engaging with friends, learning how to communicate, social interactions.

The answer is: Yes, romantic relationships and learning how to engage with our peers are a normal part of emotional and developmental growth. It's a really important part of identity formation for an adolescent; it's where we've learned our social competencies. Learning how to communicate and negotiate in intimate settings. But it's not something that just comes naturally. Healthy relationships do have to be learned. And foster youth may have had little or no exposure to healthy relationships in their, in their histories. Indeed, many of them victims of sexual, physical, or emotional abuse and have, have seen precisely the opposite of healthy relationships and may not have had very much modeling. So, we can't assume that, that they know how to do this well and we can't just assume that someone else is teaching them or covering it.

And as we said, this is, sexual development is a normal part of adolescent development. This is just an excerpt from a longer document created by several healthcare providers in the Adolescent Medicine Department at UC San Francisco. But, in general, you'll see that most adolescent development experts divide adolescent development into three stages: Early, Middle, and Late Adolescence.

Early Adolescence can start as young as nine-years-old, it's when puberty first starts, when young people may start having questions and, and seeing changes in their body. Sexual fantasies are common. They may have developments of their first crush and it's really important that they be provided accurate appropriate information to help them understand what's happening.

Middle adolescence, which can be 13 to17-years-old is when we start seeing dating and experimentation with relationships. So again, really important to provide information and support.

And late adolescence is when we would see much more pairing off and stronger relationships occurring.

So that, that helps explain why this is an important issue to cover, but there's another really urgent reason that we need to talk about this, and that's because youth in care have urgent unmet health needs. If we look at the pregnancy rates for adolescents overall in the United States, they've dramatically reduced. But, by age 19, about 50% of females who've been in foster care in California will have been pregnant, and that's a rate over two and a half times higher than we see in the general population. What's more, 20% of these young people will have been pregnant two times or more.

Now, there's a lot of myths and stereotypes about why the pregnancy rate may be higher in foster care, but what's also really important is this data. It tells us that the vast majority of these pregnancies were not intended. Indeed, when interviewing young women at age 17 who had become pregnant ,70% said that they did not intend to become pregnant when they did. 67% of young men said that.

We also know that foster youth are not accessing health care during a pregnancy, and that's leading to poor prenatal outcomes. 42% of foster youth report miscarriage or stillbirth compared to just 15% in the general population. And about 21% of foster youth never received prenatal care during a pregnancy.

The implications of these unintended pregnancies and poor prenatal outcomes end up impacting across all aspects of a young person's life. It impacts their education. By age 19, of those who had not enrolled in higher education, 30% cited the need to care for children as a major barrier. We know that there's dramatic economic costs to youth in the child welfare system. Much poorer opportunities to enter a successful job career path. And unfortunately, children born to foster

youth were three times more likely to have a substantiated report of maltreatment by age five than compared to children born to same-aged parents in the general population. Now, this doesn't mean that every foster parent is a bad parent or is abusing their child. There's many reasons that they may be reported and even end up with a substantiated report, but the bottom line is that we are creating intergenerational cycles in the child welfare system.

Now, why don't the intentions always align with reality? Why do we have 70% of young people saying they didn't intend to get pregnant and yet 50% of foster youth are getting pregnant by age 19? It's a complicated issue.

There's a lot of reasons, but what I'd like to do is just go through a couple examples. Most of these were gleaned from research done in several counties interviewing caregivers, interviewing caseworkers, and also interviews with youth. So, one thing that caregivers noted is that they don't know who has responsibility for supporting youth. And when they don't know, many, for various reasons, chose not to step in for fear of liability, for fear that this was not their role and that this would somehow hurt their relationship with either the agency or with an individual. So, as an example, we have one young person who told us, “None of my foster parents and I had 14 placements ever brought up the issue,” the issue of sexual health “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.”

We also know caseworkers feel like they don't have enough guidance. In fact, in the research in the three counties, two thirds of case workers reported not feeling adequately trained. And a vast majority of those also said that there were no policies or guidance within their agency to help them understand what was, they were allowed to do, what they couldn't do, and what they had to do. And that meant that many also avoided the topic for fear of liability or confidentiality breaches. So, just as one example, one of the caseworkers said, “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're thinking; so, I just keep focused on ILP stuff, bus passes, workshops…”

And we know that the, the, as multiple caseworkers and caregivers noted, there's, there really is a lack of policy and guidance. And that lack of state and local policies in training has led to practices that create barriers and even violate rights. So, for example, one of our young people told us, “Staff would search our rooms, and if they found condoms they'd take them away and you get in trouble.” A number of young people have reported policies that prohibited use of contraception or holding contraception. Unfortunately, this actually violates the constitutional rights of the young people and may well simply be due to a lack of training and guidance available.

It’s also important to flag that foster youth face some unique circumstances and risks that make it even more important that they receive appropriate guidance and health information. We know that youth who've experienced trauma can enter puberty up to a year earlier than their peers, so our youth in foster care may well be facing questions and, and concerns and, at a, a rate, even, at age even earlier than the general population. We know that foster youth are twice as likely to

identify as LGBTQ. This often can create barriers to their willingness to seek information or care and makes it critically important that they have access to sensitive, adequately trained health providers who can provide them appropriate guidance and, and support around their questions. We also know, unfortunately, that about 50% of young people in foster care report that they have faced forced sex or forced sexual activity at some point, prior or during foster care. Again, this makes it critically important that they're able to access sexual and reproductive health care. And, and it's important to note that over 90% of foster youth are youth of color. Many youth of color face intersectional bias and discrimination that can impact the way that they access health care, in the way that healthcare providers interact with them and so, so it puts an onus on us to make sure, again, that they, that everyone has access to appropriate high-quality health care.

So finally, the third reason that this is an important topic to discuss on the webinar is that we actually do have several new tools and rules in California. As Marymichael mentioned up front, the California Department of Social Services has created a new working group called the "Healthy Sexual Development Workgroup." It has a website where they now have a number of resources and critically, they've issued over the last few years, a series of new All County Letters and Guidance to help address many of the frequently asked questions that caseworkers and caregivers have. So, we have a lot more opportunity to implement and understand what the role of the various agencies and partners are. And, we have a new law that was passed in 2017.

Senate Bill 89, which was effective in July of 2017, includes new case plan provisions with new documentation requirements related to sexual and reproductive health care and new training provisions that impact caseworkers, caregivers, and judges.

And we'll talk more about that law as we go through the rest of the training, but for now, we are going to move ahead to talking about access and what access means. So, when we talk about accessing sexual and reproductive health care, there's really three components to creating meaningful access. We need to have a base of rights that youth have that explain what they can access and how. We need a support system around them, that, and that's all of us. And we need to have quality services and referrals available. So, in this next section we want to walk through what, what we have in each of these areas and we'll start with the rights of youth in care.

So, let's start with a case example. A residential facility sends four young women to a clinic for their health checkup. They're accompanied by a staff person. The staff person states that all the girls need an IUD because new protocol is to encourage the use of long-acting reversal contraceptive, like IUDs. 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. So, who consents for the IUDs for each of these young women?

Alright, well children and youth in foster care share the same sexual and reproductive health rights as all California adolescents. And what that means is that they have the right to consent or decline medical care and they do not need the consent of anyone else, either parent, caregiver, court order, when it's for any of the following services: the prevention or treatment of pregnancy,

and that includes any and all forms of contraception, at any age, and I really want to highlight that last clause *at any age* in California, a young person *of any age* may access contraception, pregnancy testing, prenatal care, *at any age;* they may access and consent to an abortion, *at any age;* they can consent to diagnosis and treatment of sexual assault, *at any age;* and they can consent to the prevention, diagnosis, and treatment of STI's and HIV, at age 12 or older.

So, when we're looking at our case, it's wonderful that they've been brought into a clinic and that the staff know about the various contraception off-, options available. But, ultimately each of these four young women have a right to see the health provider on their own and make a determination on their own about whether or not they want contraception and which kind of contraception they might want.

Alright. Next case: Inez is a 14-year-old youth in foster care. Her foster parent brings her to a regularly scheduled doctor's visit. When Inez called, 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 the foster mom to step outside in a little bit. Foster mom says she is required to be with Inez at all times and shall not leave. What are Inez's rights to care?

So, again, children and youth in foster care have the exact same sexual and reproductive health rights as all California adolescents and this includes the right to patient confidentiality regarding medical services and records, when it involves any services the minor can consent to, including sexual and reproductive health care. And it also means they have a right to privacy for examination for treatment by a medical provider unless this youth specifically requests otherwise. The standard protocol and practice recommended by the American Academy of Pediatrics is to offer a few minutes of private time for adolescents visiting the doctor.

This helps the adolescent learn to own their own health care and well-being. It also gives the opportunity to the provider to talk with the youth about any sensitive questions that they might have. And so, in this particular case, the provider is following the recommended practice of offering a few minutes alone, and state law gives Inez the right to that time alone with the health care provider unless she explicitly says, "I don't, I don't want that and I prefer to have someone join me."

After the provider explains the importance of private time for Inez, Inez's foster mom does agree to step out and Inez expresses to her provider that she is interested 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." So, what are Inez's rights to confidentiality?

As we just discussed on the previous slide, young people have a right to confidentiality regarding medical information and records whenever that information or records has to do with sexual

reproductive health care services, and the information, in fact, could not be shared without the written consent of the patient, of Inez in this case. So, in this case, the provider actually is not following state law; the provider would have to get Inez's permission before the provider could share information with the foster parent or, in fact, even write any of this information down on paperwork or forms that are going back to child welfare, unless there is a court order in place explicitly requiring the provider to disclose this information.

And of course, this would not be the case if this were a child abuse report. If there were any reason that the provider believes this is a youth who's at risk or has been abused, then they would follow mandated reporting protocol, but, in this case, there's, that is, there's no information suggesting that that's what's going on here.

So, as I said, I really want to emphasize the rights that we just went over are the same rights that every adolescent in California has. The reason our state put these statutes in place. and in fact. most of them are 30-50 years old is that decades and decades of research have made clear that it's the, the most important way to protect young people's health is to ensure that they have access to confidential services. Not every youth will want and exercise that option for confidentiality, but having that choice is what helps them get in the door and ensure that we're getting them the care that they need.

Now, there are some additional rights that foster youth have that others don't. So, let's cover those now. Inez has now gone back home and she asked her foster parent to drive her to Planned Parenthood. Her foster mom says she doesn't believe in Planned Parenthood and house rules are no contraception. So, what are Inez's rights in this case?

All foster youth have a right to be provided transportation to reproductive and sexual health care related services. So, in this case, Inez does have the right to request transportation or that her caregiver help facilitate transportation to Planned Parenthood. And state guidance goes further and notes that many reproductive health services are time sensitive such as emergency contraception, and therefore transportation must be provided in a timely manner in order to meet that requirement. In addition, youth in foster care have the right to obtain, possess, and use contraception of their choice including condoms. And group homes and other facilities cannot adopt policies that require confiscation of contraception particularly as part of a disciplinary program.

In addition, foster youth have a right to private storage space in their placement and to be free from unreasonable searches. So, if they wish to store contraception such as condoms, they can do that in a private storage space. They have a right to receive medical services and to choose their own provider. So, Inez has expressed an interest in seeing Planned Parenthood. She has a right to choose Planned Parenthood as her health care provider of choice and to receive medical services from them. And, if any of her rights are violated, she does have the right to independently contact state agencies to share regarding violation of the rights and has a right to be free from threats or punishment for making complaints.

Finally, and critically, youth in foster care have a right to access age-appropriate medically accurate information about reproductive and sexual health care including all of the topics listed on this slide. This is really important because again, this is stuff we often assume parents cover with young people. But in the case of foster youth we can't assume that this has always been covered. And so, if a youth asks for information they have a right to access that information and be connected to age-appropriate medically accurate information.

There's a number of resources available through the State Department of Social Services website that was mentioned earlier including a “Know Your Rights” brochure that the state created that summarizes all the rights we just discussed. And you can find several others as described on this slide.

But of course, rights don't mean anything if we don't have a support system to help ensure those rights can be effectuated. And so now I'm going to pass it to Luciana to help explain some of those rights.

Luciana Svidler: Thank You. Rebecca.

So now I'm going to talk a little about the support system, which we view as the caseworker and the caregivers and, and the adults present in the youth’s life and what their obligations are to support the healthy sexual development of the youth.

To do that, I'm going to read one case scenario, the case of Evan. Evan is 12-years-old. He has been in placement since the age of 9 and has moved school three times. Evan is currently going through puberty, he's wondering about his sexuality and has a lot of questions. He asked his foster parents where he can find out more information about these issues. So, what are the responsibilities that the caregiver has?

And let's go through those. Okay, so the responsibilities of the caregivers, which include resource families, group home staff, STRTP are as follows. They have to use Reasonable Prudent Parent Standard to support the healthy sexual development of youth. And the Reasonable Prudent Parent Standard was created to ensure normalcy for youth. This is to avoid unreasonable limitations and allow the youth to participate in age-appropriate activities. So, we ask caregivers to remember this when supporting the youth in their healthy sexual development. They must assist the youth and/or the nonminor dependent to access health services. They have to communicate with the caseworker if referrals must be made or that requires distance accessing resources and services, so if they have any issues with finding a location and service, or anything that youth under their care needs, they have to communicate this with the social worker. They have to maintain the youth’s privacy and confidentiality. They have to direct the youth to reliable sources of information. And, we're not asking caregivers to be experts in any of these issues, but they do need to know where the resources are so they can direct the youth whether it be a reliable website or a community clinic, book, public health nurse, whomever may be available. They

have to arrange for timely transportation to health-related services and STRTPs must provide a locked storage container to all youth so they can store their condoms, birth control, emergency contraception pills or any such items.

So, if we go back to the previous case scenario and it asks what must the caregiver do? We now know that they must provide them with resources and information so they can have what they need to make healthy decisions.

Evan, again, is 12-years-old, the same scenario as last time, but now he asked his foster parent where he can find out more information about these issues. And the foster parent says, “I don't know.” Evan mentions this to his caseworker at the next meeting. So, now what are the responsibilities of the, the case manager, social worker? And they must provide access to age-appropriate, medically accurate and culturally sensitive information. This is regarding sexual development, prevention of unplanned pregnancies, birth control, prevention and treatment of STI’s. And again, we don't ask that anyone be an expert on any of these sub-topics, but they have the access and means to get the information and provide it to the youth.

Some other responsibilities of case workers include informing the foster youth of their right to consent to sexual and reproductive health care, to inform the foster youth of their rights of confidentiality and written consent prior to any disclosure, to ensure that youth are up-to-date on their annual medical appointments, to ensure personal biases and a religious belief are not imposed upon the foster youth. And we will have a slide later on, on biases, but the most important thing is that they can't judge, sway, force, or coerce youth to make any decisions. They must ensure that barriers to services are addressed in a timely and effective manner. And it's important to address barriers on their monthly visits because these are very time-sensitive issues. And we will discuss barriers a little later with some examples, but this again, is critical to address as soon as possible with the youth. And finally, they have the documents certain related information in the case plan.

So, as we talked about, they, social workers must address barriers to care. And here are some very common examples of, of the barriers that youth face. The youth has questions about puberty and isn't sure who to ask. The youth may be unaware of the insurance information or doesn't have a copy of his or her Medi-Cal card. The youth doesn't know how a schedule a sexual health doctor's appointment or is too embarrassed. The youth doesn't have transportation to medical appointments. The youth reports that placement prohibits or confiscates contraception. The youth reports that placement refuses to let the youth seek sexual health care, a preferred provider. And because the placement changes, the youth misses getting the sexual ed education in school. So then these are all common things that we see in our cases, and barriers could be logistical, emotional, or informational. But what a caseworker has to do really depends on what kind of barriers that youth faces.

So, per CDSS Guidance, the caseworker has to ensure that the barriers to the services are addressed in a timely and effective manner. As I mentioned previously, a lot of these services are

time sensitive so it, it is important. The case manager is required to ask the foster youth if they're facing any barriers in accessing reproductive and sexual health care services or treatment. They have to initiate these conversations with the youth during their regularly scheduled monthly contacts. And when informing the youth of their personal rights, which has to 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 should ensure that these barriers are addressed in a timely and effective manner.

So, Theresa's a 16-year-old foster youth and she has shared with her foster parent that she's pregnant and wants to terminate her pregnancy. She has scheduled an appointment for an abortion and asked her caregiver to drive her. The caregiver shares with Theresa's probation officer that she's not comfortable with taking Theresa to an appointment for an abortion. Theresa's probation officer feels that it is the caregiver's responsibility to transport Theresa to the appointment. What are the obligations of the caseworker and caregiver?

So, I'm going to go over a little, the obligations that we discussed in previous slides. The case manager or probation officer in this case should remind the caregiver of their requirement to provide Theresa with transportation to the medical appointment, 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 or probation officer must transport her or find another trusted adult to transport Theresa to the appointment.

And, as we continue to mention, an abortion is a very time-sensitive service, so it's really important that this is done in a, a timely and efficient manner. The probation officer doesn't have to be the person to do the transportation themselves, but they do have to find a trusted adult to handle it. But, the probation officer, case manager should be giving the caregiver a copy of the CDSS Guidance, the ACL 16-82 would be great in this scenario; that outlines the youth's rights to be provided transportation and to other reproductive health, health services, rights, and what the caregiver's responsibilities are so they are aware of them. Some other best practices that the case manager can do at this point is ask Theresa who she would like to transport her and accompany her to the appointment. This is a very emotional and private experience for a youth and they might have in mind an adult that they feel comfortable with, that they would like to accompany them. The case managers can also find, find it helpful to engage the foster parent in a discussion asking them what they're worried about, why they don't want to transport Theresa, what their concerns are, and exploring these concerns with them to help them understand the issue at hand and the caregiver's perspective. By doing so, the case manager can maybe be able to provide additional information to the care-, to the caregiver which can alleviate some of the caregiver's concerns. We find that sometimes they are concerned that they would be responsive-, responsible for the decision the youth made and that's why they don't want to transport them. So, these are scenarios or issues that the case manager in conversation with the caregiver can hopefully resolve to ease the caregiver and make them more comfortable with providing the transportation. It might not be the case, it might just result in finding another trusted adult to take Theresa.

The next slide I'm, I've reference a couple CDSS guidelines that are very helpful in providing information about rights and responsibilities. Also, some guidance for case examples you have listed here, all the different resources available in the CDSS website that can be used by case managers and caregivers.

I am now going to hand it over back to Rebecca to go over the sexual reproductive health services and referrals.

Rebecca Gudeman: Thanks, Luciana.

So, at several points now, both Luciana and I, have mentioned making referrals and said you don't need to become a sexual health expert, but of course you need to know where to find those referrals and what services are available. And that's what we want to use this next section to talk about.

First though, I want to just have you take a quick look at this slide and I'm going to challenge you. After this training, go back to this website BedSider.org/Methods and see if you can figure out what each of these forms of contraception are. According to the FDA, there are at least 18 different forms of FDA-approved contraception now available. It's certainly not your grandparents' contraception and it may not be what you learned about in school. We don't need to become experts on all the different forms available, but what is important to know is that it is new and it's growing and it's changing and that what works for one person may not work for another and this is why we need to make sure we send young people to experts who can work with them to figure out what's right for them. But do try going to this website and seeing if you can guess what each of these different forms of contraception are. It's a, it's a learning experience.

Now, first, one thing we want to, we've often had questions about sort of, well, where can young people get services? It's important to know that insurance now, both public and private, must cover a really comprehensive range of sexual and reproductive health care, so when it comes to birth control under federal law and state law, both public and private insurance must pay for all forms of birth control; it must be free with no co-pays and, in fact, if someone's using something that is a monthly prescription, like pills or patches, they can get 12 months' supply at one time, cutting down the obligation to go back month-by-month to a doctor or to a pharmacist. We also have a program through our California Department of Public Health that provides free condoms to adolescents. They get mailed to their homes or to organizations. It's not available in every county but you can find out about it at the website teensource.org. See if it's available in your county.

There's also broad insurance coverage for STD screening, prenatal, and abortion care. All of those things need to be provided with no copay and with confident access, confidential access. In addition, federal law says that the Medi-Cal program must provide opportunities and funding for

sexual health education and guidance, including anticipatory guidance and, and providing advice and support to young people. And finally, we wanted to flag that state law now requires all public schools in California to provide comprehensive medically accurate sexual health education at least once in middle school and once in high school. Luciana will talk a little bit more about that law, it's just a few years old, in a little. But that is another important access to medically accurate comprehensive information for young people who are looking for answers.

Where to find services. In addition to a young person's own Medi-Cal provider, there are over 2,200 public and private clinics, health centers, public health and Department of Health providers across the state that have public funding to ensure access to free confidential sexual and reproductive health care for young people. And if you want to find the clinic closest to you or to one of your clients, TeenSource.org has something called “the clinic finder,” you simply enter your zip code, state the number of miles you're willing or able to travel, and they'll let you know which are the adolescent-friendly clinics available that provide free services so, it should be, hopefully, easy to find resources if you have a young person who's asking for help in finding, finding out where to go and get quality health care.

Alright, now we want to turn to confidentiality and documentation. As we mentioned upfront, Senate Bill 89, which went into effect in July of 2017, does have some new obligations regarding documentation in a case plan. And, in general, all of the things that we've covered thus far to the extent that it obligates a caseworker or a caregiver to intervene or provide support to youth, raises questions about what we do with that information and confidentiality. So, in a few minutes Luciana will talk more about the documentation requirements and what can and should be documented. But we thought it might be helpful to start by providing some context of the applicable confidentiality law whenever we have information being recorded by folks involved with child welfare.

As most everyone knows, Welfare and Institutions Code 827 controls release of information from a juvenile case file and juvenile case file includes all documents filed in a juvenile court case. It also includes all the reports that a social worker or probation officer might make to the court, but beyond that, it includes documents made available to the caseworker in preparation or documents related to a child whom a petition has been filed. It's a quite broad definition and so much of the information that may be captured or recorded related to services being provided or transportation could come under Welfare and Institutions Code 827.

So, what does it say? Welfare and Institutions Code 827 strictly controls access to that information in the juvenile case file. And, it, sort of, does two things, it authorizes certain entities and individuals to inspect and others to inspect and actually receive copies of that information in the juvenile case file. And on the flipside, if you're not on that list, it strictly restricts access absent the court order. But even for those who have the right to inspect or receive copies, it does sometimes restrict the type of information that is released and can restrict the use of that information, so, for example, redisclosure limitations.

In terms of who can access the file, the list, you find it in 827. We don't need to go through the whole thing, but just as an example that's particularly relevant for our discussion today, the minor's parents and guardian do have a right, in general, to inspect and receive copies of anything in the juvenile case file, as do the attorneys for the party, county counsel, and court personnel. Certain caregivers can receive the Health and Education Passport. And when it comes to inspection, members of a children's multidisciplinary team or the persons or agencies providing treatment or supervision to a minor can receive information from that juvenile case file without need of a court report.

But do they get everything? If someone's on the list do they get it all? And the answer is: No. There's a critical part of 827(a)(3)(A) that says, "If information in a juvenile case file is privileged or confidential pursuant to any other state or federal law or regulation, the requirements of that state law or federal law or regulation prohibiting or limiting release…shall prevail." That means, particularly when it comes to health, mental health, education information, we need to keep our eyes and ears open and be aware of the potential confidentiality and privilege laws that may apply to information and limit who can access it.

Some examples of the kind of laws that might apply, I won't go through all of these, but just if we think about medical information at the federal level, we have the Health Insurance Portability and Accountability Act. California, we have the California Confidentiality of Medical Information Act; we have evidentiary privilege, which limits disclosure of health information as evidenced in a court proceeding; and, in fact, we also have state and federal constitutional privacy requirements that may also be triggered and limit access to information. But feel free to look through all the others because there's many.

But what I want to do is just, look at how this, how this might play out in practice. So, let's take a look at the case of Angela. She's 15 and pregnant. She signs an "authorization to release information" form that gives her doctor permission to disclose the fact of her pregnancy and her prenatal care information to the child welfare caseworker, so that the worker can help her arrange medical appointments and make the best placement and care decisions on her behalf. However, the release form does not waive evidentiary privilege or give permission to release this information to others. Her child welfare file now contains several notes on the status of the pregnancy written by the social worker after conversations with the doctor. Angela is not ready to tell her caregiver about the pregnancy. Her caseworker, however, believes he has an obligation to inform the caregiver and include this information in the Health and Education Passport. Does the caregiver have a right to this information?

So, I want to give you a little graphic that helps us think through how you understand who might be able to access a sexual and reproductive health information in a juvenile case file. So, our first question is actually Welfare and Institutions Code 827. Since this is information in a juvenile case file, we need to know if the person requesting access has a right to inspect or receive copies of the information under Welfare and Institutions Code 827. In our particular case, we're talking about a caregiver and the possibility of releasing information through the Health and Education

Passport to the caregiver. We know that Welfare and Institutions Code 827 does allow caregivers to receive information regarding children who are. they're providing supervision and care to. So as a general matter, the caregiver does have a right to health information regarding Angela. But our next question needs to be: Is any of that health information in the file protected by other confidentiality laws?

Now, we know that health information can be protected by both HIPAA and the California Confidentiality of Medical Information Act, and when we look at those, what they say is that, in general, information cannot be disclosed to third parties without a signed authorization, written authorization or a court order. And when it comes to sexual and reproductive health care, in other words, services the minor consented to or could have consented to under state law, the minor must be the one that signs that authorization. So, the minor gets to decide who has access to her health information and she is the one that signs that release form. Now, there are exceptions in HIPAA and, and California law that allow or require disclosure of information for specific purposes like mandated reporting, but, in general, our rule is that you need the minor's explicit written permission.

So, if we go back to our case of Angela she did sign an authorization form that allows the *caseworker* to access the information, but she has not given written permission for disclosure of that information to her caregiver. That means that the caseworker cannot disclose that information to her caregiver without getting her written permission or getting an explicit court order. And, therefore, the information either needs to not be documented or needs to be redacted before being shared with the caseworker or, excuse me, with a caregiver. Now, that may make folks feel a little nervous but we're about to go into what can be documented and how this plays out in some cases.

So, I'm going to pass it to Luciana to, Luciana, excuse me, to talk more about that.

Luciana Svidler: Okay so I'm going to talk a little. I know Rebecca mentioned the new law SB 89 and new documentation requirements.

So, let's talk about what and how it should be documented in light of SB 89 and the confidentiality laws that we talked about. So, SB 89 came into effect July of 2017, so that's last year, and in it there's new case plan provisions. There's two requirements of activities that must be documented by case managers. The first requirement is that case managers document that the youth received comprehensive sexual ed education at least once in middle school and once in high school. This is for all youth who are 10 years of age or older and nonminor dependents. The caseworker has to review it annually and update the plan as needed. If the youth or nonminor dependent did not receive instruction in school, the case plan has to document how the county will ensure, has ensured, or will ensure that the youth will receive the comprehensive sexual ed education.

Now, when I talk about comprehensive sexual health education, I'm referring to the California Healthy Youth Act (CHYA). This was enacted in 2016. This is a very comprehensive sexual health education curriculum that's now required in California schools. It is, again, required in middle school and in high school. It is, it has a very broad range of criteria. It has to to be age-appropriate, medically accurate, and objective. You have a whole list of criteria down there, I'm not going to go through everything. But it also requires to cover very broad range of topics including the nature of HIV, sexual harassment, sexual assault, healthy relationships, intimate partner violence. It is actually quite extensive.

And so, youth should be receiving it in school. The case manager should be documenting when they receive it; and if they're not going to receive it, then, what they plan to do. Now, we haven't talked too much about this, but our youth in foster care tend to miss out on this very comprehensive sexual health education, which was the basis for SB 89, and this requirement of documenting it. There's many reasons why youth in foster care tend to miss out on this comprehensive education including moving a placement, so changing schools a lot, being absent from school. So, we want to ensure that our youth in care are receiving, in one way or another, whether it's in school or in an alternative form, this really wonderful information.

The other requirement is that caseworkers has to document for youth ten years of age and older and nonminors dependents that they have informed the youth of their rights to access age-appropriate medically-accurate information about reproductive and sexual health care. They have to document that they have informed the youth of their right to consent to sexual and reproductive health services and their right to confidentiality regarding those services. And, that they inform the youth how to access reproductive and sexual health care services and facilitated access to that care. And that's including helping them with identifying barriers and helping them deal with any of these barriers. Now, all this, all these requirements, these are not new responsibilities of care, of caseworkers, as I mentioned before. These, the responsibilities for them to do these things has been around. What is new is that now the caseworker has to document in the case plan to ensure that all this has happened.

So, what exactly should the caseworker or case manager document? In general, the case worker is documenting the action that they took to assist the youth, but not the protected sensitive information about the behavior of the youth, and I'll explain a little more what that means.

So, Jill is a 15-year-old foster youth. She lets her caseworker know that she thinks she might be pregnant. According to Jill, sex was consensual and the caseworker has no indication of abuse or exploitation. Jill asked the caseworker to help her set up an appointment at Planned Parenthood, but ask that she not share this information with anyone. So how should this be documented?

So, as I mentioned before, the caseworker or the agency has to document the act rather than sensitive information. So, in general practice, the way that this could be documented is that the caseworker and the youth discuss topics of reproductive health, that they provided resources and information about reproductive health to the youth, and that they offered to remove any barriers

that the you-, that the youth may be experiencing. Again, this is documenting an action but not protected information.

So, if we go back to Jill's example of going to Planned Parenthood, you would not want a document by saying that she assisted Jill with going to Planned Parenthood but that she assists to get the specific pregnancy service. But that the social worker assisted Jill or the youth in obtaining an appointment or obtaining care for reproductive and sexual health care services. So, just that, that broad sentence covers the documentation requirement without providing any confidential information or disclosing any confidential information that Jill did not consent to.

So, some best practices and things to take away from this. The agency should document the acts not the sensitive information, again. The agency should obtain the youth's written consent to disclose sensitive information, so there are situations when the youth is okay with disclosing the information. They don't mind that the report include that they're pregnant, they have no reason for hiding it or don't, are okay with having it being brought open into court, or having information accessible to those people who will read the reports, so they do consent. It is important that the social worker get written consent for this information and document that. There are times that the information has to be disclosed, such as instances where there is some mandatory reporting requirements. So, confidentiality, documentation, and when sexual health information can and should be shared, is a very complicated issue and it does require its own training because, like I said, that there are situations when there is some mandatory reporting.

Some takeaways. There's obvious no no's. So, attorneys and courts should really be watching out for the obvious breaches of unnecessary disclosure. If you ever have a question for attorneys, a client is your best resource to see if they have given consent to disclosure. But best practice is if there is information that appears to be confidential, there hasn't been any consent, it is best to redact this information from the case plan and the reports so it does not become part of the file.

Now, I'm going to talk a little about the role of attorneys and judges and what we can do to promote healthy decision-making and to ensure that our, the youth and care are making these healthy decisions and making them a reality. And the key to making the healthy decisions is four things: relationships, knowledge, motivation, and access. And by relationship, relationship, I mean having a supportive relationship between a youth and a caring trusted adult, someone that the youth can trust and with whom they can speak openly. It is very important that all the youth have this adult that they can, can share, ask questions, get information and get the help that they needed. Knowledge is having comprehensive and accurate information about healthy relationships, sex, pregnancy, contraception and all the subjects that we have talked about throughout this webinar. Motivation to make healthy decisions happens if the youth has a plans and goals and that they're working towards these goals. And more importantly, that they understand that the decisions that they're making today will affect those goals. So, the decisions they will make today will more likely be healthy decisions to help them ensure they, they meet their future goals. And finally, the youth can't make a healthy decision without having access to the tools and services that allow them to realize the decisions.

So, what specifically is the role of the court and attorneys? The role of the court and attorneys is to ensure that the appropriate person or agency meets their legal obligations related to the youth's sexual and reproductive health, to ensure that the youth receives the support and knowledge needed to make healthy long-term decisions regarding sex and pregnancy planning, and finally to ensure that the youth has the tools and access to make these decisions a reality.

So, more specifically, I'm going to cover what the minor's attorney's role is in working with their clients, and that is to help them identify the trusted adult. We talked about how important it is for the youth to have a trusted adult to ensure that they have access to accurate information, to support them in planning for their future, the motivation piece that we've referred to earlier, and to advocate for access to services and information and to address barriers.

So, how to help them identify a trusted adult? One way to do it is to ask them directly who is their trusted adult? If they can't identify it, what steps can be taken to identify one? So, help them find who is, who they're close to in their life, who can they lean on and ask these questions and be there for them. And sometimes it could be the attorney themselves is the trusted adult, it could be a CASA, it could be a social worker, it could be a caregiver or even their parent. The child's attorney should assume that no one else is talking to them about sexual health, in fact, most, most youth especially foster youth report that they have not had any conversation about sex or reproductive health by any adult in their life. It's never too early to start these conversations about sex and relationships. Of course, the conversations have to be age- and developmentally-appropriate, so if you have a younger child you might be talking about puberty and good touch versus bad touch. As they get older, you're talking about healthy sexual relationships, so this may vary depending the age of your client. And you should always have an open door for questions and conversations so they're comfortable with, with you and discussing these issues. The attorney should ensure that they have access to accurate information and we've talked about earlier in the webinar, that there's different people who are responsible for ensuring that they have accurate information, but the attorneys should ensure that this is happening. They should confirm that they have received information from the caseworker or the caregiver. They should ensure that they will receive the comprehensive sexual health education in school. If they're not, or they've missed it, ensure that the social worker is planning for a way for them to get this information at a future date. Ensure that they know about local resources and referrals. They can have with them a list of referrals, clinics, pamphlets, information to give out to their clients. And know where to look for answers, again, just like everyone else, attorneys are not required to be experts in this field. But they should have the knowledge of where to look for this information and refer the clients, point them to the right direction. And most importantly, they should not impose their values on their youth.

As far as motivation, the attorney should support for planning for their future. That means what, finding out what they would like to do and what you can do to help them to achieve those goals; what supports and services are in place to maintain the stability in the youth's placement. Education, extracurricular activities, these are all things that will help with their goals, reaching

their goals, and helping with their motivation. The attorney should ask open questions and provide support like, “What do you want to do when you grow up?” “How can we make your dream a reality?” And, in this way, elicit the information that you need to ensure that they have the proper motivation and goals and that they reach their potential.

And as far as advocacy, the child's attorney should ask the youth and the caseworker to inform them if there's any barriers to health care or issues with placement. This is, again, a conversation that should be had at every meeting with your client so you can address the issues head-on as they come up and since some of these issues are very time-sensitive. Ensure the youth’s sensitive, confidential, and/or privileged health information is not disclosed in the case plan, unless the youth has given written authorization to do so, written consent as I discussed before. So, at any time, if you read a report that has confidential sensitive information, ensure that that is redacted as soon as possible so it doesn't spread farther than it needs to. And be prepared to request for the court’s assistance in ensuring the agency and the caregiver are complying with their obligations. So, if at any point you find that the social worker, the caregiver, is not meeting their requirements as we discussed them earlier, it might require a request of the court to ensure that everyone is following what their legal responsibilities is.

So, some tips for communicating with youth when we're talking about reproductive and sexual health issues include stressing positive attributes of the teen and praising their good work, to deliver clear messages, listen and treat their comments seriously, inform communication by reflecting on your own experiences as a teen, keep a sense of humor, and find moments for conversations. And we know that these are hard conversations to have so it does require some thought before going into the conversation, some practice, and also a good relationship with your client to make these things a little easier. The things we don't want you to do is to compare them with other teens, to lecture or moralize them, to be judgmental or over overly critical, or to engage in power struggles. And, this can really just go for pretty much any topic area that you're talking to youth with, not just reproductive and sexual health but we find them especially useful when dealing with those conversations.

And as part of LA RHEP for Foster Youth, we do have a youth advisory board and we have asked them for their thoughts about how they, how the youth want themselves to be communicated with, and this is what they had to say:

They believe that the attorney should be inclusive and not gendered in how they asked questions, so, for example, you want to ask, “Are you in a relationship?” instead of “Do you have a boyfriend?” Use broad open questions to watch physical cues for signs of anxiety or stress.

You really want to see how your client is reacting to your questions, how comfortable they are, their comfort level before you push into an area that they're not comfortable with.

You don't want to assume that they're all sexually-active or that they're not. Some of them said that they may already have experienced something non-consensual, and, as Rebecca mentioned

very early on in the webinar, youth in foster care tend to have had other high, they're more likely to have had something non-consensual happen to them. So, they do have a history here. It might bring up some issues that are hard to talk about, so that's something to take into consideration and account when you're talking to your client. But also, don't set a lower bar for them just because they're foster care, and that was very important.

Make sure that there are no language barriers. And I don't just mean language as in foreign languages, but just the words that you're using to make sure that they understand. So, you can ask a follow-up question, "Did you, did you understand what I said?" Sometimes we talk in words, lingo that are not easy to understand, and, so, in order to get an accurate answer, it's important that everyone's on the same page and we all know what we're talking.

Some of the phrases that they would like to hear from their attorney are:

"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."

So, these are some quotes that may be helpful in working with clients.

And now, to talk about, talk a little about the role of parent's attorneys, I'm going to pass it on to Marymichael.

Marymichael Smrdeli: Thanks, Luciana.

So, we've talked a lot about children in foster care and their rights and caregivers as well as caseworkers, but we haven't spent a lot of time on parents and their, and the parent's attorney's role in these cases. So, I think, often times we forget that parents are part of this system in this particular way. We, we don't often ask them their input on, on reproductive health topics or what conversations they have had with the foster youth. Even though that youth is not and their care anymore, they're still the parents, they still may have educational rights, and in our child welfare and juvenile justice proceedings, the goal is to actually reunite the children with the parents, and so, the parents need to know what's going on and they need to be informed of what the youth is going to be talked to about.

So, the role of the parent's attorney is really, to provide the clients, their clients with information on how to be a trusted as a prudent parent to the teen or to the youth. And, as Rebecca was saying earlier, some of these issues, some of these pregnancy issues, are multi-generational. And so, we might be representing a parent who wasn't parented themselves, and so they're not quite sure how to be a trusted and supportive parent to a teen. And accompanying this webinar, we

have a lot of resources that are available to parent's attorneys to be able to give their clients, to teach them some of these tasks. And also, just making sure that the case plan, if the parent does have a teenager or an older foster youth, that the case plan maybe has a parenting class that's geared towards that age group rather than maybe just a general parenting class for all different types of age groups. The issues maybe for, for teenagers and older foster youth are different, and maybe those classes might help the parent be able to have these conversations and learn how different strategies to parent this particular population of youth.

Also, the parent's attorney should discuss with the parent that this is the right of their child, that their child must be informed of their sexual and reproductive health rights and access to these services in an age- and developmentally- appropriate way. We know in our foster care system that our parents come in with the varying backgrounds and varying ideas and a lot of different ideas and upbringing, so when the parent's attorney talks their clients, they should be asking them, you know, "Have you had any conversations about reproductive health rights with your child?" "What are your beliefs around this area?" "What are your concerns around this area?"

Now, as we talked about earlier, you know, the case worker has to the document that the children, the foster youth were given this information in an age-appropriate manner, which means that it's pretty much early on in the case that the caseworker would have to be having these discussions with the foster youth, so we're hoping that the parent and the social worker can talk and the parent's attorney can inform the parent that these conversations will be happening, you know, prior to the first case plan being developed where the parent might look at this information and see this information for the first time, that this is being discussed with their child. So, we're hoping that that doesn't happen and that best practice would be to have this conversation with your client to let them know that this is, that the reproductive health rights information and access to that information and services will be discussed with their child.

The role of the parent's attorney is also to reassure the parent that all adolescents have these rights that it's not just about their particular child and to, to advise the client to talk to the social worker or probation officer with any concerns they have. They may have religious concerns, they may have concerns just based on their own experiences, and so it's really important for the parents to be able to talk to the social worker or probation officer about any of those concerns. And also, the parent's attorney's role is to review the case plan with their client and discuss any issues in this area that cause their client any concerns.

There's a lot of resources for the parents and their attorneys, so there's a few here. Talkwithyourkids.org that have handouts in English and Spanish and then there's a lot of other handouts as well that are accompanying this webinar that you can check out.

Ok, so now we're going to talk about the role of the court and judicial officers. So, the role of the court, so as we talked about there are these new case plan requirements, so the court's job is to review the case plan and find that the agency complied with the case plan requirements.

Specifically, in this context, such that the caseworker has verified annually that the youth or the nonminor dependent received or will receive the comprehensive sexual health education that meets the criteria that Luciana had talked about, at least once in junior or middle school and at least once in high school. So, the court when looking to the case plan, should ask, sort of, what does verify mean? When is health education offered in the school district? So, for example, a youth may currently be in a middle school that offers sex education in eighth grade or this comprehensive sexual health education in eighth grade. However, because of placement needs, they're moved to a different school district that actually provides this particular education in sixth grade. So, and this child is moved in seventh grade, and so, therefore, maybe this child has not had that sexual health education through this school district, meaning that court then has to sort of ask the agency and the caseworker how the youth will be receiving their sexual health education.

So, the court may want to ask the worker what, if they know, or ask the school district or ask the workers to check with the school district, when these, this education is going to be offered in that particular school district just to make sure that this has not gone through, gone through the cracks.

The other issue that the court has to look at in terms of this specific resource regarding sex ed, sexual health education is that we had talked about previously, that parents may hold educational rights. And, in California this is, this comprehensive sex health education is an opt-out provision, so meaning all the youth are in unless the educational rights holder specifically opts them out. And so, even if a parent, who is the educational rights holder, opts their child out of this particular course in school, that doesn't relieve the agency and the caseworker of their obligation to provide this information. It's the youth's right to receive this information and receive this education. And the court should be monitoring that as well to make sure that, even if the parent has, is the educational rights holder or anybody who is the educational rights holder, it could even be a care provider, who has, if they have opted out of this education, that the agency will provide this education in a, in a similar, in an alternative fashion.

The court must also find that the agency complied with the case plan requirements that for youth ten years of age and older, including nonminor dependents, the youth has been informed of their right to access age-appropriate information as well as consent to sexual and reproductive health rights and been told about that confidentiality rights regarding these services. So, in this particular context, the court should be asking itself, the judge, or the bench officer, "What does it mean to inform?" And like anything else in juvenile cases, everything's done sort of on a case-by-case basis and everything should be case-specific. So, you might have a 10-year-old who is, or 11-year-old or 12-year-old, who is age-appropriate, will understand in an age-appropriate way the information that the caseworker is trying to tell them, and you might have an 18-year-old where you can just hand them a pamphlet and that would be fine. But you also may have those situations where you have a 16-, 17-, or 18-year-old that is delayed, that has some issues with processing and may not be able to internalize the information in a way that another person may. So, in terms, they may get, it may take some more time, it may take a longer conversation, it may

take simpling down words. And like Luciana said making sure they understand the language that you're using, to really make sure that is, that the youth has been informed in an age-appropriate and developmentally appropriate manner. So, the court should be asking if they have concerns about what they're seeing in the, in the case plan or the report. They should be asking the caseworker exactly how this information was given to them, to ensure that they were informed appropriately of these rights.

And then, finally, the court must find that the agency's complied with the case plan and that the caseworker has informed them of their access to reproductive and health, sexual health care rights, and they facilitated access to care including addressing any barriers to care as needed. So, in this particular context, we're talking about what does "facilitate access to care" mean (including addressing any barriers)?

Some of these things as Luciana and Rebecca has said, have said earlier, are very time-sensitive issues, and so, sometimes the court may not know exactly what's going on or what barriers have been addressed. They just may know that the agen-, there have been some and the agency has addressed them.

Other times, the court may be asked to be the one to step in to address barriers or facilitate access to care. And, in these situations, I would urge the court to be very careful about the information that they receive; for example, if the barrier is access to health care rights to procure abortion services, the court should be concerned about if the youth has given ac-, given permission for any of that information to be shared, if the court has been given permission to have that information. And, if the court has been given permission to have that exist- information, but maybe the parents, the youth has not given the parents access or given them permission to have that information, then the court should consider if they, if they have this information, filing it under sealed, keeping it in a sealed portion of the court file, so that really, no one else has access to it and without a court order.

So, some of the things that judges might ask, again, judges are not supposed to be experts in these areas, but the judge does have power in the courtroom to do things. So, the court can ask, "Do you have someone to speak with you? Do you have a trusted adult, you know, in your life?" The law, for many years, has contemplated that the youth, we should not be breaking up the youth's community if they have someone that they can trust, and we should be asking them and trying to keep them in contact with the important individuals in their lives. And so, it should be pretty easy for a worker to tell the court who the special person is or the, or the youth to tell the court if they have someone that they could speak with, that they have someone that can be trusted, that the youth trusts. If the court asks this question, "Do you have someone you can speak with?" or "Do you have a trusted adult in your life?" And the youth doesn't, then I think that's an issue that the court should be addressing. I know that in one of the courtrooms in California, the judge, this is expected in her courtroom, that this question will be answered and even at calendar call, an attorney will say, "I don't know who this person is yet, I'm going to follow up and try to get to an answer prior to this case being called on the record." So, judges

should use their influence to try to figure out who the trusted adult is in the youth's life. The court can ask the youth if they're there, if they're aware of their rights to services and information, if they've been connected to any resources. The court can also ask, you know, "Is there anything else you need?" "How else can we help you?"

Being in front of a judge is, is highly motivating to youth in terms of, you know, having someone that is making orders for them in their family. So, the court can ask, "What do you want to be when you grow up?" "How can we make your dreams a reality?" "Do you want to have a family someday?" Some of those motivational questions that the court can ask so that the youth really feels like someone's paying attention and listening to them. Also, I would point out that the court should be looking at the Transitional Independent Living Plan too, and maybe asking questions about the goals that the youth has listed there, to follow up on, to make sure that we are, we have a path for the youth, and that the youth has a path that they want to pursue.

And then, access as to these services, you know, "Are your health needs being met?" And the court can ask those questions and then, again, the court doesn't have to have the answers, and the court doesn't need to be the expert on these areas; but, the court can direct people to help the youth if the youth feels like they're not being supported in these ways or has access to the appropriate reproductive health information or services that they need. So, again, the Youth Advisory Board was asked about communicating with judges and this is, sort of, their quotes from these perspective that, you know, judges can be scary. I'm sure not all youth want to talk to court, but, talk to the judges.

That, the "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 comfort level, or our level of comfort."
"Have a specific conversation about our rights, benefits and resources- no specifics." For example: "Have you received the information you need?"
And finally, "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."

So, these are some of the, the quotes from the youth's perspective about what it's like to communicate with a judge.

Okay, and so now, we are going to be talking and bringing all these things together. So, I am going to turn this over to Rebecca to sort of lead us in a conversation about, about bringing all of these things together.

Rebecca Gudeman: Great, thanks Marymichael.

So, we have a series of cases we're going to present, and I'm going to ask our other panelists to help answer the questions. So, our first case is Sunny. Sunny's a 14-year-old girl who walks into

court and is visibly pregnant. There's no mention of the pregnancy in the court report. The judge does not have any additional information about the pregnancy's circumstances, motivation, etc. So, our first question is: Should the judge address the pregnancy with the youth in open court? And if so, *how* should the judge raise the issue? So Marymichael, what are your thoughts on that?

Marymichael Smrdeli: Well, like we said before on the previous slide, those, the youth don't want the judges to ask them about specific questions and would rather ask their attorneys or address the issue prior to coming into court. So, youth should not address the issue with the pregnancy in open court. I know that is counterintuitive to a lot of judges; they would like to, sort of, really get in there and ask them these questions, especially if they've seen the youth in court for a long period of time. But they should not; they should not ask the youth specifically about their pregnancy, or if they're pregnant. But what they should do, what the judge can do is ask the youth how they're feeling, if there's any needs, if there's anything that they need, if their needs are being met. Some of those, sort of, open-ended supportive questions.

Rebecca Gudeman: Okay, great. And so, there's no obligation to say, "Congratulations!" or say the kinds of things that we normally feel like we're obligated to say?

Marymichael Smrdeli: No, there's not. And, in fact, they may not want to be congratulated. We don't know.

Rebecca Gudeman: Yeah, exactly. Thanks.

Okay, our next case is Jaime. Jaime is a 16-year-old who's 30 weeks pregnant. 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 for the birth. So, I guess, the first questions are to you again Marymichael, is such an order necessary and how should the court handle this request?

Marymichael Smrdeli: No, an order is not necessary. And, in fact, it should not be submitted to the court because it has to do with Jaime's own reproductive health rights regarding the delivery and care of her child. I will, I will say that this is often a practice that we see and I don't know where that practice stuff was started. But, if the court does receive one of these requests either in child welfare or juvenile, or juvenile justice proceedings, whether through a social worker or probation officer, the court shouldn't sign it and I know that the courts may be concerned that if they don't sign it, then the provider won't give Jamie the care that they need.

So, what I would suggest the court to do if that they get one of these orders, that they call either the probation officer or the child welfare worker or the attorney for Jamie, and tell them that they've received it, that there, they shouldn't receive it, that they're really not authorized to have this information, and he'll let the provider know basically what Jamie's, that Jamie holds these rights and their her rights, which may then prompt child welfare or probation off-, probation to

have a more intense conversation with the provider regarding the foster youth's rights regarding reproductive health. But the court should not file it, should not sign it, and should shred it upon receiving it.

Rebecca Gudeman: And Luciana, what if anything should Jamie's attorney do when they see this coming through?

Luciana Svidler: So, first I'd like to say that, you know, a lot of times an attorney will not see this, just to make clear, because a lot of these orders do come to the judges off-the-record and attorneys do not find out but if they happen to find out that this kind of request was submitted to the court, they should do exactly what Marymichael said and first contact the social worker and also the medical provider to, kind of, go over their rights with them, of the youth. And so, they know that such order is not needed especially with the medical provider to ensure that they understand these rights, that they do not need a court order, that they will be able to provide the medical care and services that the youth needs, and, as, as needed; and that it won't delay any of the medical care that the youth will get. It's also a good opportunity for the child's attorney to reach out to their client to ensure that they're receiving the services and care that they need, that they're not facing any barriers, and just to ensure that, that they have what they, what they need.

Rebecca Gudeman: Great. Thank you.

Let's go on to our next case, Angel. The judge receives the court report on 17-year-old Angel. The report states that Angel recently was prescribed and is using PreP, the pre-exposure prophylactic HIV medication, now available and approved for adolescence. There's no indication in the report or file that Angel authorized disclosure of this sensitive information. So, our first question is: What, if anything, should the court do? And may the court order the agency to redact this information? Marymichael?

Marymichael Smrdeli: Well, yes. The court should ask whether Angel gave permission for any of this information to be disclosed. And if Angel did not give permission for any of this information to be disclosed or, or only gave permission for specific people to receive this information, the court should order the agency to redact this information, not only in this report, but future reports that come to the court.

Rebecca Gudeman: Now, what if the report states Angel was diagnosed with HIV or another STI and receipt and, is currently receiving daily medication, does that change our answer? And Luciana, why don't you give us your thoughts on this first?

Luciana Svidler: I do not think that changes the answer at all. I think that it raises some concerns with folks because these diagnoses require continuous care and treatment and services. But, at the end of the day, I do not believe it changes the answer. I do think that this information is confidential and should not be included in a report absent consent from the youth.

Rebecca Gudeman: And Marymichael, any additional thoughts?

Marymichael Smrdeli: No, I mean I agree with that. I think what would happen in this case if the caseworker, I think, in general, sometimes the caseworkers are concerned about continuity of care for Angel. In case Angel moved placements or things like that so they feel like they have to report this information to ensure that Angel is getting his or her needs met. But that does not, that's Angel's information to be disclosed as he or she is still fit.

So, it doesn't change my answer. I would say that a lot of people, for example, if Angel was receiving this medication but may also be receiving other medication for mental health issues that might be psychotropic medication. Those issues, those psychotropic medication issues would be the ones that come to the court, not the daily medication or any medication that has to do with any health care that Angel may be receiving.

Rebecca Gudeman: Okay. Thank you.

Alright now, we'll go to our final case, Miranda. An attorney receives a phone call from her client Miranda. Miranda says she ran away from her placement because she's four months pregnant and a family member told her that the child welfare agency will take away her baby if she gives birth while in foster care. She isn't going to the doctor right now because she's afraid the doctor will turn her into child welfare or to the police. What, if anything, can or should the attorney do? Luciana, do you want to start us on this?

Luciana Svidler: Yes, this actually brings up a ton of issues that the attorney should be talking to her client about. I mean, I think it opens the doors for conversations to explain to Miranda her right to consent to services, her right to confidentiality. Also, just to have a conversation about how and when possibilities of the baby actually going into care, discussing their fears or concerns because we don't know what kind of information the family member gave them. We know people here say all kinds of things about what a social worker may or may not do. So, it's good to go over, kind of, those. What are the, what are credible fears and what are not?

Also, to discuss the importance of receiving medical care for herself and her child. I felt, I think also it's important to offer to call the doctor and explain to the doctor also Miranda's right to consent and to confidentiality services to-, so, they're aware that, because we know that sometimes the medical community is not aware of this, and, but you have to make sure that your client understands that there is a risk at some point when you go to the doctor that a social worker may be called. So, you want to make your client aware of all the possibilities, the whole range of possibilities, so they can make an informed decision on their own. Now, having said that, I, I think it's important to discuss with the client *why* they're AWOL, why they do not want to come back to the child welfare system, what's been happening, what's the problem is, if it's a concern about their placement or the previous placement or their baby, to try and work with them and to offer that support that they need to make the most informed and healthiest decision for themselves and their child. It may just be that coming back into the system and helping them find

a great placement for them and their child could be the best option for them. So, you can talk to them about that, or, you know, maybe staying out of the system is what they ultimately want. And, you know, with, as an attorney, we ensure our clients that we're not mandatory reporters, that we want to make sure that they're safe, we're not going to turn them in.

But, just really discuss the whole range of possibilities for them both medically and also within the child welfare system, placement and all, to help come up together with what is the best possible solution and plan for them and in, in the future of their pregnancy. I'm not sure if I even covered it all because it entails a long conversation with a client about so many different issues.

Rebecca Gudeman: Thank you.

Luciana Svidler: But really being open about what all the different possibilities are.

Rebecca Gudeman: There's one thing you said that I just want to raise up. While she certainly has a right to confidentiality when she goes to get prenatal care, it is true that not every provider is aware of all of these rights. And you mentioned letting her know that, but I do think it's also important to flag that probably in every county, we could find a provider who is trained in providing care to adolescents and understands these issues. And part of what we can do is help make sure that we know what the good referrals are so that even as she's sorting through *all* of the other issues you mentioned, we can get her into care and make sure that she and her unborn child are being taken care of and that she's getting access to prenatal care because as we flagged in the beginning, we know that up to 21% of pregnant foster teens are not getting *any* prenatal care and this is leading to some really devastating pregnancy outcomes.

Marymichael, did you have any final thoughts on this one, before we close up?

Marymichael Smrdeli: No, I mean I think I agree with everything Luciana said. And if it, if she does return to the care, custody, and control of the child welfare system or probation system, then the court would have a hearing and then the court could make sure that all the case plan requirements that we had talked about previously were being met.

Rebecca Gudeman: Alright. thank you. And, that's it.

Luciana Svidler: And, and-

Rebecca Gudeman: Oh sorry, go ahead Luciana.

Luciana Svidler: No, no. I was going to say that was an excellent point you raised. I think was, as the attorney, we think about dealing with their current doctor which that's why I was recommending calling the doctor. But, it is true that youth have the right to go to any medical provider of their choice, and I think we underutilize that right by going and finding the most appropriate doctor or a doctor or provider that the youth feels comfortable with. That's it.

Rebecca Gudeman: Okay. So that is it, for, we have here a list of additional resources and contact information for each of the presenters. The website, FosterReproHealth.org is the website for the Los Angeles Reproductive Health Equity Project, which is, as Marymichael said, a public-private partnership of many organizations including the child welfare agency there. And you can find a lot of additional resources on the site. And with that, I'll pass it back to you Marymichael.

Marymichael Smrdeli: Alright, well thank you. Thanks everybody for listening. Thank you, Rebecca and Luciana, for their expertise and in this area, his very complicated area. And for the copies of this webinar as well as all the information that we've talked about and handouts, you can go to the courts website at www.courts.ca.gov and if you will now complete your, the survey that is an evaluation, that is attached to this webinar, that would be helpful for us and then you will receive your continuing education credit for this presentation. So, with that, I will bid everybody adieu and say thank you and goodbye.