

Pregnant and Parenting Teens  
in Foster Care  
in Fresno County , California

WHO ARE THEY AND  
HOW CAN WE HELP?



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Nancy M. Richardson  
Consultant  
First 5 Fresno County  
nrichardson@co.fresno.ca.us  
Fresno County Department of  
Children & Family Services  
2011 Fresno St. Fresno, CA 93721  
(559) 905-5878 or 453-3924

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## ntroduction

Since late 2007, First 5 Fresno County has provided a consultant to the Fresno County Department of Children & Family Services to assist the Department in improving services to children ages birth through five who come into its care. The focus during 2008 was on improving the Department's work with infants and young children who become Dependents of the Court due to abuse or neglect. First 5 also urged that the Department look at the well-being of infants and young children who *are not* Dependents of the Court but who live with their teenage parents who *are* in foster care. First 5 was alerted to the issue by a few reported instances in the community of these young children receiving substandard care by their teen parent and by the apparent confusion in the community about how these children's needs can be attended to. The Department enthusiastically endorsed the idea of a detailed look at the subject.

This paper constitutes one intermediate step in a months' long process of exploring the many complex issues around pregnant and parenting teens in foster care and their children. It is based on dozens of interviews with social workers, their supervisors and program managers, pregnant and parenting teens, nurses, educators, and a host of others who work with these teens and their children. It also reflects current literature on the topic.

There are two target audiences for this paper. One is the internal workforce of the Department, which needs to have an understanding of the topic which is more detailed than may have been offered in college or in subsequent trainings. The second audience is the wonderful array of community partners who also work with these youths. The question has been asked by community partners, "What makes your pregnant and parenting teens different than other pregnant and parenting teens?" This paper attempts to explain that the fact of being in foster care constitutes a significant factor whose implications must be acknowledged and accommodated.

The recommendations herein should be regarded as a first-level response, not a comprehensive recipe. This first level addresses the matter of how the Department can organize its people to actively engage in problem-solving on the many strands which need attention. Once mechanisms are put in place for doing so, dozens of issues will be identified, and solutions will be devised and implemented. The active engagement by many people in the Department, in conjunction with community partners and relying heavily on the advice of the teens themselves, will ensure that this effort is substantive and sustained.

Regarding terminology, there are several uses of shorthand. One is that whenever there is reference to “the Department,” this means the Fresno County Department of Children & Family Services. Also, the term “foster care” is used to denote all forms of out-of-home care for children who are Dependents of the Court—foster homes, group homes, guardians, relatives, etc. In addition, it should be noted that the opinions herein are those of the consultant.

## **I**magine

Suppose you are 15 years old and you are pregnant. And suppose, further, that you have been in foster care for much of your life, moving from one home to another, say, a half-dozen times. In addition, more than a few of the following descriptors apply to you:

- You have little contact, no contact, or a strained relationship with your birth mother.
- Your birth father is unknown, in prison, or has been missing from your life for years.
- Your mother has a long history of substance abuse.
- You have been seriously physically abused as a young child.
- You have been severely neglected as a young child.
- You have been sexually molested.
- You have not sustained over time a satisfactory relationship with a mental health therapist.
- You have been diagnosed as having asthma and other chronic health problems.
- Your anger and sorrow regarding abandonment by your parents go to unfathomable depths.
- You have attended many schools, and your likelihood of graduating from high school is small.
- You have been prescribed medications by a psychiatrist to treat depression, mood disorders, or other serious conditions.
- You have been using alcohol and other drugs.
- You are acquainted with the use of violence as a problem-solving method.
- You have had many social workers and had an optimum relationship with only a few.
- You dislike being in foster care and don't understand why you were not born into a typical family.

You are not alone. In May, 2009, there were 18 pregnant and 24 parenting girls in foster care in Fresno County. These are the ages at which they became pregnant:

<u>Age</u>	<u>Percent</u>
13	2
14	22
15	44
16	17
17	15

Of the pregnant girls, five already have one child and one has two children. Also, there are two pairs of sisters, and several have an older sister who gave birth as a teen. People who have been involved in this topic for years note that there have been several 12-year-olds who have been pregnant while in foster care.

These numbers represent only the pregnancies and the births of which the Department is aware. At any time, there are new pregnancies as yet undiscovered or undisclosed, and there are pregnancies which are terminated without the Department's knowledge. Until this year, there has been no tracking of pregnancies or births to teens in foster care in Fresno County. Even now, the tracking mechanisms are imperfect.

Nineteen of the forty-two pregnant and parenting teens have been on runaway status at some point during their time in foster care, often during pregnancy. The number of placements while in care ranges from 2 to 33, with the average being 8.8. Not all are changes to a new placement; some of those changes might represent returning to a previous foster home.

Fifty-two percent of this group are Hispanic, 19% are African-American, 17% are White, 10% are Native American, and 2% (one person) is listed as mixed race.

Imagine, given their life circumstances, how well these young mothers, as well as the fathers of their children, are prepared to meet their own needs and to simultaneously provide care for their children. Actually, some of them do quite well. Close observers say pregnancy sometimes has a settling effect on girls whose lives have been chaotic. Many teens in foster care are quite articulate about their desire to provide their babies the stable, nurturing home which they never had. Some will make good on that hope; others will unwittingly feed the cycle of abuse and its co-occurring problems.

This paper will provide an overview of risks to pregnant and parenting teens in foster care and their children, because it is essential to understand the

breadth and depth of the risks and the implications of those risks. Equally importantly, this paper will discuss the factors which promote resiliency and give our pregnant and parenting teens in foster care and their children a decent chance of avoiding lives of suffering.

## **B**eing Adolescent—and Pregnant

Perhaps the greatest risk for teenage parents is that their own maturational processes are put on hold or otherwise compromised. **A primary task in the teen years is to figure out one's identity—a particularly problematic enterprise for kids who have little or no sense of their family of origin or of their place in the world.** They may have few guideposts which direct them as to ancestry, family history or trajectory, continuity with loved ones, a familial or other support network which can be relied upon now and into the future, a network to help with attaining employment, etc.

Many have coped with their bewilderment by indulging in a host of high risk behaviors, which take them further away from developing a mature identity. The very fact of pregnancy involves, at any age, a profound rethinking of one's identity. This effect is magnified in teens, who are still learning about their body and their reproductive function, who are likely to be disconnected from their own birth mother, and who are rocked by the changes which pregnancy itself brings.

Pregnant teens are isolated from many typical peer support systems and are very likely to fall seriously behind or drop out of school altogether. Many people assert that the current emphasis on test scores has caused comprehensive high schools to direct pregnant and parenting teens to "independent study" programs, further placing them outside of the mainstream of teen life.

Teenage fathers suffer similar problems with identity formation and other normal developmental tasks. If they take their fatherhood seriously, they are in a markedly different life situation than their peers, thus increasing isolation. They are not likely to be included in medical appointments or other key events with the mother of their child. If the mother is in foster care, her placement can be changed without regard to whether the baby's father can easily maintain contact with her and their child.

**An essential task of all teens is to develop lasting, healthy relationships based on trust, respect, and a clear understanding of love—what it is and what it is not.** All humans need to be loved. Some have it from birth and have no great difficulty attaining loving relationships. Others, especially children who have been neglected and abused, desperately crave love and engage in relationships which are at core, exploitative and abusive. Many

pregnant teens in foster care plan to marry their baby's father and live as a family when they are old enough. Social workers say that rarely happens.

Economically, both teen mothers and teen fathers have a greatly reduced income-earning potential, given the likelihood that they will achieve low educational attainment. Those who have strong support networks can beat the odds, but most will not.

Physically, pregnancy during the teen years poses risks because bones are not fully formed, and physical growth and maturation are not yet complete. For pregnant teens who indulge in high risk behaviors such as substance abuse or smoking, or who have sexually transmitted diseases, there may be a host of adverse consequences, some with lifelong impact.

Teens in foster care are as different from one another as a crocus is different from a zinnia. It is important to point out that some of them are just fine and exhibit little impact from their removal from their parent(s.) Others exhibit a host of troublesome behaviors. Thus, generalizations apply to them as a group, but not necessarily to each individual in the group.

## Effects of Childhood Stress

It is important to understand the impacts of stress on children, because it sheds light on what might differentiate most pregnant or parenting teens in foster care, in general, from pregnant or parenting teens who have not been subjected to marked, multiple, and/or prolonged deleterious childhood experiences. A paper entitled *The Effects of Childhood Stress on Health Access Across the Lifespan*, published by the U.S. Centers for Disease Control and Prevention, references the Adverse Childhood Experiences (ACE) Study which links “specific 1) violence-related stressors, including child abuse, neglect, and repeated exposure to intimate partner violence, and 2) risky behaviors and health problems in adulthood.”<sup>1</sup>

The paper notes that The National Scientific Council on the Developing Child has identified three types of stress:

1. Positive stress—challenging situations which can be managed and overcome

<sup>1</sup> Middlebrooks JS, Audage NC. *The Effects of Childhood Stress on Health Access Across the Lifespan*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

2. Tolerable stress--intense stress which, with help, can become managed and become positive stress, or can devolve into toxic stress if the child does not receive sufficient support
3. Toxic stress—intense adverse experiences over a long period of time, such as abuse and neglect, which may activate a stress response over a prolonged period, which can lead to permanent changes in the development of the brain

It goes on to state that “When a child feels threatened, hormones are released and they circulate throughout the body.”<sup>2</sup> Prolonged exposure to stress hormones can impact the brain and impair functioning in a variety of ways:<sup>3</sup>

- Toxic stress can impair the connection of brain circuits and, in the extreme, result in the development of a smaller brain.
- Brain circuits are especially vulnerable as they are developing during early childhood. Toxic stress can disrupt the development of these circuits. This can cause an individual to develop a low threshold for stress, thereby becoming overly reactive to adverse experiences throughout life.
- High levels of stress hormones, including cortisol, can suppress the body’s immune response. This can leave an individual vulnerable to a variety of infections and chronic health problems.
- Sustained high levels of cortisol can damage the hippocampus, an area of the brain responsible for learning and memory. These cognitive deficits can continue into adulthood.”

In the ACE Study, a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, participants’ exposure to ten particular adverse childhood experiences emerged as critical elements. The ten mirror quite precisely the experiences of many children who are in foster care:

- Abuse
  - Emotional
  - Physical
  - Sexual
- Neglect
  - Emotional
  - Physical
- Household Dysfunction

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<sup>2</sup> Ibid., 3.

<sup>3</sup> Ibid., 4.

Mother treated violently  
Household substance abuse  
Household mental illness  
Parental separation or divorce  
Incarcerated household member

Children in foster care are likely to have also experienced the death of loved ones or abandonment by or separation from loved ones—factors which could certainly be added to the list of adverse childhood experiences but which were not identified as such in the ACE study.

The ACE study concluded that as the number of ACE experiences increase, the risk for that person for the following health outcomes also increases:

Alcoholism and alcohol abuse  
Chronic obstructive pulmonary disease  
Depression  
Fetal death  
Illicit drug use  
Ischemic heart disease  
Liver disease  
Risk for intimate partner violence  
Multiple sexual partners  
Smoking  
Suicide attempts  
Unintended pregnancies

The report goes on to state, “*ACE are also related to risky health behaviors in childhood and adolescence, including pregnancies, suicide attempts, early initiation of smoking, sexual activity, and illicit drug use*”.<sup>4</sup> [emphasis added]

Some of the additional findings from the ACE Study are worth listing, because they are often descriptors of teens in the child welfare system:

- Participants who were sexually abused as children were more likely to experience multiple other ACE.
- The ACE score increased as the child sexual abuse severity, during, and frequency increased and the age at first occurrence decreased.
- Women and men who experienced child sexual abuse were more than twice as likely to report suicide attempts.

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<sup>4</sup> Ibid., 6.

- A strong relationship was found between frequent physical abuse, sexual abuse, and witness of IPV (intimate partner violence) as a child and a male's risk of involvement with a teenage pregnancy.
- As the frequency of witnessing IPV increased, the chance of reported alcoholism, illicit drug use, IV drug use, and depression also increased.
- Exposure to physical abuse, sexual abuse, and IPV in childhood results in men being 3.8 times more likely to report IPV perpetration.
- Higher ACE scores in participants were linked to a higher probability of both lifetime and recent depressive disorders.
- Those with higher ACE scores were more likely to have 30 or more sexual partners, engage in sexual intercourse earlier, and feel more at risk of contracting AIDS.<sup>5</sup>

## The Impact of Trauma

Of the eighteen teens in foster care in Fresno County who were known to be pregnant in May, 2009, the average time from entry into foster care to then was just under six years. Ten of the eighteen ran away from foster care at least once. Some were on runaway status while pregnant. Their foster care records are replete with notations about molestation, serious mental illness, domestic violence, substance abuse, health problems, and a host of other "adverse childhood events."

Researchers do not fully understand why some people have adverse lifelong consequences to early exposure to trauma while others do not. However, the following hypotheses have been offered as variables.<sup>6</sup>

- The meaning of the event to the individual
- The severity and chronicity of the event
- Predisposing characteristics of the individual such as emotional regulation and other genetic predispositions
- Previous experiences of trauma or loss
- How young the child was at the time of the trauma
- The support system available to the individual following the trauma

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<sup>5</sup> Ibid., 8-10.

<sup>6</sup> Landy, S., Menna, R., *Early Intervention with Multi-Risk Families: An Integrative Approach*. Baltimore (MD): Paul H. Brookes Publishing Co., 2006, 262-3.

Recent studies have concluded that “the combined effects of risk factors are more devastating than the sum of their individual effects.”<sup>7</sup> **If children are in foster care in their teen years, they are likely to have had prolonged exposure to a long list of risk factors.** To think they have not experienced debilitating trauma is akin to thinking that Fresno is beset with snowdrifts in August. The few exceptions are those rare instances in which a youth has been in a single placement, often with a relative, for a period of years.

It is important to understand the impacts of trauma, because it is key to understanding these teens, and perhaps their response to their own infants and toddlers.

Landy and Menna cite a number of ongoing effects of trauma, summarized here:<sup>8</sup>

- The intrusion of traumatic memories, which may result in the person being restless, hypervigilant, and easily scared
- Out-of-control actions, which can result in unplanned abuse or violence
- Chronic stress, which may result in anxiety or panic attacks, obsessional preoccupations, sleep disturbances, hyperirritability, arousal, and attention to irrelevant cues
- Gradual withdrawal from everyday activities, leading to feelings of emptiness, abandonment, and betrayal
- Compulsive exposure to dangerous situations, possibly resulting in revictimization, self-cutting, eating disorders, risk taking and substance abuse, or the victimization of others
- Altered ability to attend and process information
- Loss of trust in the world
- Alterations in relationships, due to problems with trusting others or, alternatively, being too trusting and oblivious to warning signs
- Poor self-perception, seeing oneself as weak, shameful, and unlovable
- Health problems, including an increased risk for infection
- Extreme difficulties with emotion regulation, leading to uncontrolled rage, anxiety or depression

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<sup>7</sup> Ibid., 7.

<sup>8</sup> Ibid., 267-9.

Social workers will recognize these traits in the most challenging teens on their caseloads. These attributes help explain why a subset of teens in foster care experience frequent placement changes, runaway episodes, and failure to engage in their own schooling in any significant way. In all likelihood, it also may explain the impulsive behavior which led to the pregnancy. Many teens in foster care get pregnant due to denial that this might actually happen to them. Others plan to get pregnant, announce that they intend to, and find a way to make it happen—all in a manner which suggests an ultimate act of defiance and control. With few exceptions, however, pregnant and parenting teens in foster care voice a profound desire to be good parents, lest their child suffer as they have suffered.

## Mental Health Conditions

Of the eighteen teens in foster care who were known to be pregnant in May, 2009:

- One was diagnosed with asthma, migraine headaches, ADHD, and dysthymia with depressive features. She was treated once for threatened suicide. She was thought to have been a sexual perpetrator, and had used crystal methamphetamines. Pregnant now, she went off her psychotropic medications and instead self-medicated with marijuana.
- Another was listed as having been anemic and chemically dependent.
- Another had a sexually transmitted disease, was diagnosed with ADHD.
- One had experienced two previous miscarriages (not a mental illness but events which may cause distress)
- Another was diagnosed with chronic delayed post traumatic disorder, major depressive disorder, and agoraphobia.
- Of the sixteen who were clients of Fresno County Children's Mental Health Department, two were diagnosed with post traumatic stress disorder, 6 with anxiety, 10 with depressive disorders, 1 with mood disorders, 1 with psychosis, 3 with ADHD, 3 with dysthymic disorder, and 4 with behavior disorders.

One study lists expectant or new mothers who are vulnerable to

depression as those who have:<sup>9</sup>

- Previous history or family history of mental illness
- Stressful life events
- Chronic or acute health problems
- Limited support
- Family violence; substance use/abuse
- Relationship difficulties
- Unrealistic expectations of motherhood

Without a doubt, depression and mood disorders are very common in Fresno County's pregnant teens in foster care. Sometimes these disorders go untreated, often because the teen does not continue to avail herself of treatment. Of the 16 teens who were pregnant in May, 2009, and who were known to Fresno County Mental Health, the date last seen in care was 2001 for one teen, 2006 for another, 2007 for three, 2008 for 4, and 2009 for seven.

Dr. Shaila Misri, clinical professor in Psychiatry and Ob/Gyn at the University of British Columbia and Medical Director of Reproductive Mental Health at St. Paul's Hospital in Vancouver, British Columbia, argues that psychiatrists must think carefully about the treatment of mental illness during pregnancy.<sup>10</sup> She lists consequences of non-treatment as:

- Poor prenatal care
- Risk of medical/obstetrical complications
- Exacerbation of psychiatric illness through postpartum
- Self-medication/substance abuse
- Impaired bonding

She also notes that suicide is one of the three leading causes of maternal death. She points out that no decision—to treat with antidepressants and benzodiazepines in pregnancy and lactation versus allowing the illness to go untreated—is risk free. She and others provide guidance on clinical findings regarding which medications may be given under what circumstances to whom, during the perinatal period.

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<sup>9</sup> Bodnar, D. *Educate, Screen & Intervene with Perinatal Depressed Women: An Innovative Program*. PowerPoint presentation at 2<sup>nd</sup> Annual Perinatal Mood and Anxiety Disorders Conference. April 23, 2009. Fresno, California, Reproductive Mental Health BC Women's, [www.bcwomen.ca/Services/ReproductiveMentalHealth](http://www.bcwomen.ca/Services/ReproductiveMentalHealth).

<sup>10</sup> Misri, S. *Antidepressants & Benzodiazepines in Pregnancy & Lactation*. PowerPoint presentation at 2<sup>nd</sup> Annual Perinatal Mood and Anxiety Disorders Conference. April 23, 2009, Fresno, California. Reproductive Mental Health BC Women's Hospital & Health Centre. Vancouver (BC)

It is not unreasonable to guess that in Fresno County, pregnant teens so far are rarely, if ever, afforded the benefit of a thoughtful discussion with their medical provider about the risks versus benefits of utilizing psychotropic medications for severe conditions during pregnancy and lactation. It is unknown how many are screened for depression, anxiety, or other disorders. There are many reasons to think that anxiety, depression, and fear about the future feed the runaway and other high-risk behavior of these teens.

## Pregnant Teens and Substance Abuse

Of the pregnant teen cohort discussed in this report, only two have been screened by the Department with the Addiction Severity Index instrument. Thus, only those two have had their case reviewed by the Department's substance abuse specialists and linked to appropriate treatment. It is often the teen's attorney or the Court who makes the referral, rather than the social worker. Case notes make frequent references to current or past abuse of alcohol or other substances in more than just these two cases. Because the vast majority of these teens are the children of substance abusers, and because their own lives are likely to have been chaotic, there is a significant predisposition for substance abuse. Obviously, this subject needs attention.

## Pregnant Teens and Education

Generally, youths in foster care who entered at an early age and who moved frequently from one home to another have experienced poor school attendance and earned low grades. Sometimes youths who entered the system as teenagers experienced a chaotic life previously and are, therefore, low academic achievers. In spite of the fact that some of these teens are very bright, low achievement can be the product of poor attendance, frequent school changes, or inattention to special educational needs. Several of the pregnant teens in Fresno County have notations in their file indicating poor attendance in the first few years of schooling due to lengthy and repeated episodes of head lice. It is very hard for a child to overcome the educational deficit of lengthy absences during kindergarten and the primary grades.

Pregnant teens are at a particular disadvantage for schooling. They must cope with health challenges, medical appointments, and fatigue, not to mention the social isolation which may come with pregnancy. Most of Fresno County's pregnant teens in foster care bounce from a comprehensive high school to a continuation school or to a charter school offering an independent study program. Often there are gaps of a few months when the teen might be enrolled but does

not attend school at all. Few have access to transportation other than the City bus system. Most are woefully behind in accumulating high school credits.

Social workers have their work cut out for them trying to find a suitable education option for each pregnant teen and then trying to keep the teen on track. An added complication is that the worker needs to help the teen find a school setting that will be appropriate once the baby arrives—preferably one which has on-site or nearby child care.

There are success stories. They are girls who have inner drive, good cognitive abilities, and a support system to help and encourage them.

## T<sup>een</sup> Pregnancy Risks to Babies

According to studies quoted by the March of Dimes, teenage mothers are “at greater risk than women over age 20 for pregnancy complications, such as premature labor, anemia, and high blood pressure. These risks are even greater for teens who are under 15 years old. They are also more likely to have babies who die. The March of Dimes Fact Sheet states, “Babies who are premature and low birthweight may have organs that are not fully developed. This can lead to breathing problems, such as respiratory distress syndrome, bleeding in the brain, vision loss and serious intestinal problems. Very low birthweight babies (less than 3 1/3 pounds) are more than 100 times as likely to die, and moderately low-birthweight babies (between 3 1/3 and 5 1/2 pounds) are more than 5 times as likely to die, in their first year of life than normal-weight babies.”<sup>11</sup>

Low birthweight and prematurity carry developmental consequences, as noted in studies cited by Landy and Menna:<sup>12</sup>

- The lower the birthweight, the greater the risk that the child will have ongoing health and developmental problems, especially if there are other neurological complications (Allen, Donohue, & Dusman, 1993; Downie, Jakobson, Frisk & Ushycky, 2003; Hack, Taylor, & Klein, 1994.)
- Chronic medical conditions, frequent hospitalizations, and repeated illnesses can be difficult for families to manage, and can be related to later psychosocial and academic difficulties when the child enters school (Offord, Boyle, Fleming & Blum, 1989; Schultz-Jørgensen, Kung, Maar, Rasmussen, & Højlund, 1987.)

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<sup>11</sup> Teenage Pregnancy, Quick Reference: Fact Sheets, March of Dimes, [www.marchofdimes.com/printableArticles/14332\\_1159.asp](http://www.marchofdimes.com/printableArticles/14332_1159.asp). downloaded 6/15/09.

<sup>12</sup> Landy, 8.

- Difficult temperament characteristics, such as a high response to various stimuli or irritability, can lead to persistent arousal of the child's sympathetic nervous system, resulting in anxiety, irritability, intensity of response, and other reactions (Coll, Kagan, & Resnick, 1984; Thomas, Chess & Birch, 1968.)
- These characteristics of the "difficult" child have been found to be very challenging for parents and children, and were related to more acting-out and other emotional problems in later childhood and adolescence (Lee & Bates, 1985; Thomas & Chess, 1985.)

## R ecent California Study

A report released in March, 2009, entitled *Sex Education and Reproductive Health Needs of Foster and Transitioning Youth in Three California Counties*<sup>13</sup>, developed by the Public Health Institute's Center for Research on Adolescent Health and Development, should make people who care about the subject dance with joy. It is thoughtful, thorough, and supremely useful.

The three-county study included Fresno, Orange, and San Francisco Counties. It addresses four questions:

1. What are the sexual and reproductive health needs and challenges of foster and transitioning youth?
2. What barriers stand in the way of addressing these needs and challenges?
3. What suggestions do staff and former foster youth have regarding these needs, challenges, and barriers?
4. What should be done to promote foster and transitioning youth's sexual and reproductive health and to address the issues and challenges that these youth face?

In addition to reviewing extant research on the subject, the researchers conducted telephone interviews with staff and foster parents, conducted web-based surveys of social workers, and conducted focus groups with foster teens

<sup>13</sup>Constantine, WL, Jerman, P, Constantine, NA, *Sex Education and Reproductive Health Needs of Foster and Transitioning Youth in Three California Counties*, Public Health Institute, Oakland CA, March, 2009, <http://crahd.phi.org/FTYSHNA-FullReport-3-2-09.pdf>.

and former foster youth. The resulting analysis of qualitative and quantitative information led to a series of recommendations.

The report begins with sobering information about the risks for children in foster care:<sup>14</sup>

- Children and youth in foster care are often characterized by the absence of a dependable family or social network, an intense need for affection, the desire to possess something of their own that they do not have to share, exposure to sexual abuse, exposure to other types of violence, and limited skills in identifying and accessing resources to support themselves now and in the future. (Becker and Barth, 2000.)
- Studies have shown that youth who grow up in and emancipate from foster care are likely to have poor outcomes in education, employment, housing, and physical and mental health. (Aarons et al., 2001; Courtney et al., 2007; Garland et al., 2001; George et al., 2002; Pecora et al., 2006.)
- Foster and emancipated youth are also at increased risk for unintended pregnancy, HIV, and other sexually transmitted diseases due to high-risk sexual behaviors such as unprotected sex and sex with multiple partners (Becker and Barth, 2000) and young women who had been in foster care are more likely to have been pregnant than same-age peers who had not been in foster care (Courtney, et al., 2007.)

The report goes on to summarize findings of a University of Chicago longitudinal survey of foster youth:

- Despite their greater likelihood than their peers of having access to counseling and sex education information, young women who were in foster care were almost twice as likely to have ever been pregnant than their peers (33% versus 19%.) Two-thirds of the young women who were in foster care and had been pregnant said their pregnancy was unwanted, in comparison with over half of their peers. Young women who were in foster care, however, were far less likely to have had an abortion (9%) than were their peers (36%; Courtney, Terao & Bost, 2004.)
- At age 19, the young women who had been in foster care were more likely to report having ever had sexual intercourse (90% vs. 78%.)
- *At age 21, 71% of young women who had been in foster care had ever been pregnant, as compared to 34% of their peers. Half of the young men who had been in foster care reported that they had ever gotten a female*

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<sup>14</sup> Ibid., 4.

*pregnant, compared with 19% of their peers who had not been in foster care.[emphasis added]*

Because the responses to the questions are so well-formulated, they are worth quoting exactly (but without the fascinating explanatory material which accompanies each response in the report.)

**Question 1: What are the sexual and reproductive health needs and challenges of foster and transitioning youth?**

1. Adolescent pregnancy is largely accepted in the youth's families of original and by their peers.
2. Foster youth often have intense unmet needs for love and a sense of belonging.
3. Foster youth sometimes become pregnant to try to hold onto a partner.
4. School-based sex education is not always available or known.
5. Not all foster youth obtain sex education through ILP [independent living programs.]
6. Having knowledge does not imply use.
7. Absence of consistent, supportive, and trusted adult to talk with.
8. When foster youth become pregnant, they do not always get counseling on pregnancy options.
9. Responsibility for connecting pregnant youth with prenatal care is diffuse.
10. Staff do not consistently offer subsequent pregnancy prevention information to youth who were pregnant.
11. Staff do not consistently discuss preventing subsequent pregnancy with foster parents caring for pregnant youth.
12. ILP caseworkers appear to discuss prevention issues less frequently with male than with female foster youth.

**Question 2: What barriers stand in the way of addressing these needs and challenges?**

1. Unclear policies, unclear roles, and liability.
2. Inadequate communication on sexual risk prevention between CFS social workers and ILP caseworkers, and foster parents and other caregivers.
3. Some CFS social workers and ILP caseworkers believe they are not adequately trained.
4. Diversity of religious and moral beliefs and values.

**Question 3: What suggestions do staff and former foster youth have regarding these needs, challenges, and barriers?**

1. Sex education should be provided through ongoing group presentations.
2. Sex education should start earlier.
3. Sex education should include peer-to-peer components.

4. More compelling information on the dangers of STDs should be provided to foster youth.
5. Youth should be trained on how to use condoms.
6. Youth should have the opportunity for frequent one-on-one discussions on sex-related issues with trusted adults.
7. Foster parents, social workers, and caseworkers should receive more training.
8. Foster youth gender issues should be better addressed.
9. Information and resources should be more accessible, including free condoms.
10. Pregnant youth should receive additional services.

**Question 4: What should be done to promote foster and transitioning youth's sexual and reproductive health and to address the issues and challenges that these youth face?**

This question is addressed in the Summary and Recommendations, which are summarized here:

**Recommendation 1:** Counties should develop and implement specific policies, plans, and procedures to help prevent pregnancy and STDs and promote sexual health among foster youth. These should include specification of appropriate roles for all adults who care for youth, including CFS social workers and ILP caseworkers, public health nurses, foster parents, and other caregivers.

**Recommendation 2:** Foster youth should have regular access to ILP and non-ILP workshops on comprehensive sex education, including but not limited to methods of contraception and HIV and other STD prevention, personal goal setting, positive relationships, and information on what raising a child entails.

**Recommendation 3:** Foster youth in their early teens should have access to sex education prior to becoming age-eligible for ILP [their mid-teen years.]

**Recommendation 4:** Training should be provided on various aspects of adolescent sexuality and reproductive health for all CFS staff, including supervisory staff as well as social workers, and for ILP caseworkers and foster parents.

**Recommendation 5:** Staff and foster parents should routinely initiate discussions with youth around the issues related to sexuality, including self-image, relationships, goal setting, planning and decision making, and protection from STDs, unwanted pregnancy, and exploitation.

**Recommendation 6:** Policies should be developed to ensure that a full range of services are provided to pregnant youth, including counseling and pregnancy

options, assistance in preventing subsequent pregnancies, and linkages to providers of prenatal care.

**Recommendation 7:** Information and resources should be presented together on-site, including condoms.

**Recommendation 8:** Recruitment processes for caretakers in foster homes as well as group homes need to clearly state that foster youth must be allowed to attend school-based, ILP-based, and other community programs providing sex education.

**Recommendation 9:** Section 16521.5 of the California Welfare & Institutions Code should be fully funded and implemented. As a first step, a formal analysis of its current implementation should be fully conducted. [The statute states that a foster care provider—or when the provider objects, the county case manager—is to see that adolescents in long-term foster care receive age-appropriate pregnancy prevention information. Compliance is required only to the extent that funding is allocated to implement this, and this has not happened.]

The report concludes by stating, “Addressing these needs will require substantial long-term efforts, and counties cannot be expected to meet this obligation alone....Counties are encouraged to form strategic partnerships with other public and private agencies and with outside experts who are active in this field.”

## Resiliency

While it is critically important to have a clear-eyed understanding of the risks inherent in being a pregnant or parenting teen in foster care, it is equally important to be fully grounded in the elements of resiliency. A book published by WestEd titled *Resiliency: What We Have Learned* by Bonnie Benard, is a compendium of research and a common-sense guide.<sup>15</sup>

The book cites the findings of long-term studies of youth who are in high-risk situations:<sup>16</sup>

1. Resilience is a capacity all youth have for healthy development and successful learning.

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<sup>15</sup> Benard, B. *Resiliency: What We Have Learned*. San Francisco (CA): WestEd. 2004.

<sup>16</sup> *Ibid.*, 4.

2. Certain personal strengths are associated with healthy development and successful learning.
3. Certain characteristics of families, schools, and communities are associated with the development of personal strengths and, in turn, healthy development and successful learning.
4. Changing the life trajectories of children and youth from risk to resilience starts with changing the beliefs of the adults in their families, schools, and communities.

The author states that four personal strengths have been outlined which constitute resiliency, and each has sub-parts:

Social Competence

- Responsiveness
- Communication
- Empathy and Caring
- Compassion, Altruism, and Forgiveness

Problem-Solving Skills

- Planning
- Flexibility
- Resourcefulness
- Critical Thinking and Insight

Autonomy

- Positive Identity
- Internal Locus of Control and Initiative
- Self-Efficacy and Mastery
- Adaptive Distancing and Resistance
- Self-Awareness and Mindfulness
- Humor

A Sense of Purpose and Bright Future

- Goal Direction, Achievement Motivation, and Educational Aspirations
- Special Interest, Creativity, and Imagination
- Optimism and Hope
- Faith, Spirituality, and Sense of Meaning

Actually, these attributes coincide with what social workers try to develop in the teens they work with. They are what the Judicial officers want for the children under their purview. They are what teachers, care providers, mental health clinicians, and others want for our teens, and also for themselves. None of us wants to be considered a "problem" to be "fixed" by external pressure. We would rather own our own lives, make our own decisions, recognize and solve our own problems, and consider ourselves capable of functioning in this world.

The book provides what it calls a simple recipe—caring relationships, high expectation messages, and opportunities for participation and contribution.<sup>17</sup> Even more importantly, it notes that, “As documented by Werner and Smith (1992), the most powerful protective factor in the life histories of resilient children was the presence of one caring adult in the child’s life, most powerfully a parent, but often a mentor or surrogate parent.”<sup>18</sup>

The three-county study quoted in a previous section of this report echoes these sentiments. It states, “There is a compelling need to help connect transitioning foster youth to caring, committed adults who can serve in this role both before and after a youth has left care. In the long term, sex education and reproductive health services should be interwoven with other child welfare improvement efforts to holistically address issues such as absence of trusted adults, low expectations, and the need to belong, all of which can contribute to risky sexual behaviors and pregnancy.”<sup>19</sup>

Resiliency research demonstrates that even in children who are subject to multiple serious risks, half will emerge eventually as responsible adults.<sup>20</sup> Benard warns against excessive reliance on the predictive value of risks. Instead, she promotes attention to protective factors, “the supports and opportunities that buffer the effect of adversity and enable development to proceed, [which] appear to predict positive outcomes in anywhere from 50 to 80 percent of a high-risk population.” She goes on to quote “Werner and Smith, ‘Our findings... suggest that these buffers... make a more profound impact on the life course of children who grow up under adverse conditions than do specific risk factors or stressful life events... [T]hey offer us a more optimistic outlook than the perspective that can be gleaned by the literature on the negative consequences of perinatal trauma, caregiving deficits, and chronic poverty’ (1992, p. 202.)”<sup>21</sup>

## P

### arenting by Teens in Foster Care

There is a paucity of research which is specific to teen parents who are in foster care. Nonetheless, the many research findings cited by Landy and

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<sup>17</sup> Ibid., 43.

<sup>18</sup> Ibid., 51.

<sup>19</sup> Constantine, 35.

<sup>20</sup> Benard, 7.

<sup>21</sup> Ibid., 8.

Menna<sup>22</sup> are important and sobering. Various studies find that in general, teenage parents, compared with adult parents, are likely to be:

- Less sensitive and responsive to their infants and young children
- More likely to misread infants' and young children's cues
- Less likely to understand developmental issues
- More likely to expect too much of their infant and young child
- More likely to have difficulty coping with toddler behaviors
- More likely to make negative attributions about their child
- More likely to have difficulty with their own emotional regulation
- Less likely to talk to their infant and young child often

Studies of mothers (of all ages) who are depressed show similar deleterious impacts on their children. "Mothers who are depressed tend to be less responsive and more helpless, hostile, critical, and disorganized as a result of their feelings of lack of self-efficacy (Cutrona & Troutman, 1986b; DeMulder & Radke-Yarrow, 1991; Teti, Gelfand, Messinger & Isabella, 1995.)"<sup>23</sup>

The breadth and depth of the potential problems demonstrate the enormity and urgency of the need for attention to the factors which promote resiliency—of the parent(s) and the infant or young child. For a Child Welfare agency, this, has to be a high priority.

**In Fresno County, there has been no system in place to track teen pregnancies among foster youth, nor has there been specific attention to the well-being of the children of foster youths.** Further, there is no way (short of reading thousands and thousands of referrals) to study the number and kind of referrals alleging neglect or abuse of our foster teens' children. Nor is there any way to track actual adjudicated abuse or neglect of these offspring. Some people in the community believe that the Department of Children & Family Services pays too little attention to these offspring, and to reports that they are being abused or neglected by their foster teen parent. Others believe the Department is too quick to remove these offspring, spending far too little time and attention helping their parents to resolve any issues which have arisen.

It should be noted, too, that some foster teen parents do a poor job with their first child but if given sufficient help, might do well with a subsequent child. In general, teens in foster care express a strong desire to be effective parents, so that, as one stated, "I don't mess up as badly as my mom did."

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<sup>22</sup> Landy, 18.

<sup>23</sup> Ibid., 20.

## Fathers

**In every study of teen fatherhood, fathers voice the sentiment that they are largely forgotten.** The systems in place to provide prenatal care to the mother often make no attempt to include the father. Once the baby is born, fathers are likely to experience distancing from the mother, as her time and attention are focused on the baby. The fact of motherhood and fatherhood means that the couple can no longer spend their time and energy on the normal processes which lead to a maturing relationship—or not.

Legal issues also have the effect of limiting the father's participation in the child's life. There may be concerns about statutory rape or about arrangements for custody.

The Child Welfare System pays little attention to teens in foster care who are fathers or to other fathers of the children of teen mothers who are in foster care. That is not to say that individual social workers are inattentive to the fathers. They might or might not know the identity of the father or have any working relationship with the father. If they are inattentive, they might arrange for a new placement for the mother without any consideration as to whether the location of the new placement makes it feasible for the father to maintain contact with mother and child.

A question on a required form completed by older foster teens asks whether the person has been pregnant or has fathered a child. For males who answer in the affirmative, there is no particular service or support that is offered, except to the extent that a particular social worker takes the initiative to do so.

## Policies and Practices

**The Department lacks policy guidelines and an infrastructure sufficient to reliably carry out formal or informal policies regarding reproductive health for children and youth in foster care and their progeny.** Social workers are unsure of what the Department expects of them, so most do not talk to their youthful clients about sex or about pregnancy prevention. Few workers talk to male youths about sexual responsibility or about their legal or moral responsibilities as a father. Few workers know much about community resources for pregnant or parenting teens. And, workers are most likely to see their obligation to the progeny of foster teens as very minimal.

The Department is inching toward implementation the Whole Family Foster Care option, enacted into law in 2005, which entails development of a Shared Responsibility Plan which delineates—for the caregiver, the teen, the social worker, and the Foster Family Association representative—who will do

what regarding the teen and their baby. This has the potential to eliminate the pervasive friction between foster parents and teens regarding the care of the child. It could also contribute to a reduction in placement changes for the teen and baby.

## Comments

It is easy to come up with the “what” of what needs to be done. The recommendations from the “Sex Education and Reproductive Health Needs of Foster and Transitioning Youth in Three California Counties,” listed in this report, are a good place to start. The “how” and more importantly the “by whom” parts are far more difficult.

As this report is being written in June, 2009, California is in severe financial chaos which is likely to get much worse. Nobody can predict what resources will be available tomorrow or next week or next month. Although it might be tempting to wait to see what settles, that would be a great disservice to the young people in our care—as well as the infants and young children born to the teens in our care. Nobody would wish for such chaos, but since it is here unbidden, in a perverse way it affords the opportunity to rearrange the pieces while they are in the air.

In order to formulate recommendations which might actually get implemented, it is appropriate to comment first on how the Child Welfare System is organized. The system is organized by functions which coincide with the sequence of events as a case moves through the system. There are divisions for early intervention, initial assessment and intake, family reunification, assessment, permanency planning, and adoptions. Each division has huge volumes of work, short timeliness, immense complexity, and an ever-changing workforce. Their work is subject to the scrutiny of the Dependency Court. In general, they perform a never-ending series of tasks in a fashion that is prescribed as to form but widely varied by virtue of the unique situations involved. The Department’s work is measured intensely against federally-prescribed outcomes with the aid of a detailed statewide data system.

However, the Department operates without a support system sufficient to engage in crucial support functions, such as planning, analysis, interaction with potential partners, etc. It is easy to say, “Somebody needs to check on X,” and then realize that there is no somebody to do that. In addition, as has been noted in reports about the Department dating back to the 1970’s, the ongoing training function continues to get short shrift, both as to content and as to attendance by busy social workers when training is available.

The issue of pregnant and parenting teens in foster care and their children is one that has received little organizational focus for a variety of reasons, including these:

- It is not part of the voluminous federal outcome measures.
- There is no easy way to provide tracking in the main software tools developed by the State.
- Pregnancy and parenting can occur in teens whose cases could be in any of the divisions of the Department, so there is no obvious central point of responsibility.
- There has been no gifted leader who is organizationally appropriate, inspirationally suited, and time-wise available to lead.
- It is “one more thing” in an already overwhelming set of responsibilities.
- The absence of a Departmental policy framework connotes that this is not important.
- The absence of meaningful, sustained training leaves people without the tools necessary to do the work.
- The lack of a multi-disciplinary mindset or ongoing multi-disciplinary structures make it difficult to do this work.
- Although individual social workers are doing great work on this topic, this varies greatly from one worker to another.
- Social mores and ethical and religious beliefs may, in the absence of clear direction and legal guidance from the Department, interfere with good practice and with teens’ rights.
- Adults are very likely to have considerable inner conflict about their own experiences with sex, pregnancy, and parenting.
- Adults are not necessarily knowledgeable about birth control or about pregnancy options, including adoption or abortion. Many are not comfortable talking about these topics.
- Social workers whose clients are teens may have been exposed to very little training about what to look for regarding their teen clients’ care of their infants and young children. Also, they believe they have only very minimal responsibility for the little ones.

Fortunately, the Department has some wonderful assets to work in doing some serious and lasting problem-solving. Among them are these:

- Notwithstanding their nervousness about feeling inadequately trained, social workers are eager and animated when discussing it. They *want* to do good work.
- The dozens of people interviewed for this project, to a person, believe we can make improvements.

- Having just finished the first school year basing many social workers at the high schools which their clients attend, a shake-down cruise of sorts, the next school year will afford these workers the opportunity to enjoy the close relationships which can be attained from proximity and consistency.
- For teens who have the same County social worker for their entire high school years, that one special confidante that everybody needs might easily be that social worker.
- There is a corps of school-based mental health clinicians who can work closely with teens who are identified as needing mental health services and can consult with social workers, caregivers, and others as appropriate.
- CalSAFE (California School Age Families Education) programs, Early Head Start, Early Intervention, Adolescent Family Life Program, and other programs in our communities have unparalleled expertise in working teen parents and with their infants and young children. They do a wonderful job of working with our teen parents and their children; the Child Welfare system doesn't have to do everything itself.
- Infant-family and early childhood mental health is a topic whose time has come. Considerable attention will be paid in the coming months and years to beefing up the knowledge and practice of this in our communities.
- Although we will likely suffer a net diminution in resources in the coming months, there is still plenty of opportunity to make improvements by better utilizing whatever resources we can muster.

## Recommendations

1. The Department of Children & Family Services Executive Team can designate responsibility to named individuals who will take the lead to develop and implement Departmental policies and action plans and provide ongoing leadership to:
  - a. Utilize existing or new mechanisms to assure that the youth voice is heard as each policy or strategy is developed and utilized.
  - b. Educate appropriate staff about their responsibilities regarding reproductive health education needs of children in foster care from age 10 and up. Provide the information and tools necessary to carry out this responsibility.

- c. Assemble a short-term work group to draft a written policy and procedure guide for the Department regarding the legal and moral responsibilities of the Department for the well-being of non-dependent children of dependent teens.
  - d. Assemble a short-term work group to decide how best to monitor and attend to the health needs (including mental health) of pregnant teens in foster care. Then implement an ongoing plan for this purpose. Assure that teens are informed about pregnancy options.
  - e. Assemble a short-term work group to prepare and distribute a Fact Sheet for pregnant and parenting teens in foster care, describing their rights and responsibilities.
  - f. Assemble a short-term work group to study options and recommend how best to provide parenting education for pregnant/parenting foster teen females and males. Examine curricula and also consider various delivery systems. Include information on safety, health, and social-emotional needs of infants and young children.
  - g. Assemble a small group to identify all the options for child care for the infants and young children of teen mothers. Obviously, the mother is responsible for child care. Identify her options so that she can go to school, go to various appointments, or manage when she is ill.
  - h. Develop written descriptions of education options for pregnant and parenting teens, including commentary on each.
  - i. Within ILP, identify and implement training for youths regarding personal goal setting, positive relationships, and related topics.
  - j. Assure that pregnant or parenting teens are screened for substance abuse and linked with treatment as needed.
  - k. Attend to the needs of males, including education on sexual responsibility and the responsibilities of fatherhood.
  - l. Assure that there is a Shared Responsibility Plan for every parenting teen in foster care.
2. The Executive Team will need to aspire to see that the product of each of the above elements becomes embedded in the day-to-day work of the Department. All of the work should be designed to ultimately:

- a. Reach 100% of the youths in the target group
- b. Be considered ongoing work, rather than "pilot" or "project" work
- c. Be subject to ongoing review and revision, as needed, by the Executive Team
- d. Coordinate with other available Technical Assistance efforts
- e. Be implemented across all task areas
- f. Make optimum use of community partners

**This work is very do-able, and there will be many hands and hearts to bring practical help and a joyful spirit to this important work.**