Risking Their Future: Understanding the Health Behaviors of Foster Care Youth

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Executive Summary

The foster care system should be a refuge for children who’ve endured neglect or abuse, providing a fresh start after years of dysfunction. But often, adolescents get drawn into a pattern of risky behavior that threatens their well-being and future success. They have sex too early and often, leading to sexually transmitted diseases, pregnancy or both. Too many foster care youths exit the system with young children of their own and no road map to navigate the challenges of parenthood or adulthood.

It’s easy to cast a teen mother in foster care as promiscuous and irresponsible. The 16-year-old father is a caricature too: selfish, immature and fueled by testosterone. But the truth is more complicated. Their lives have been profoundly shaped by past traumas, and they live in a foster care system that fails to provide the stability, education, health and mental health care they desperately need.

In a sense, these teens and young adults are stranded—unable to escape a past where coping with daily life meant drinking, using drugs, having sex or engaging in other risky behavior. Absent intervention, many repeat the mistakes their parents made, bringing a new generation of children with them.

New York State can—and must—help these young adults break the cycle by closing gaps in the foster care system, investing in additional education, health and mental health services for foster care youth, and collecting data to monitor the sexual and reproductive trends among this population.

With Risking Their Future, the Schuyler Center for Analysis and Advocacy (SCAA) provides a detailed portrait of the challenges facing foster care youth and the implications for their sexual behavior. It also provides specific recommendations to help policymakers take action that will enable teens in foster care to make good choices about relationships, sex and parenting.

This report looks at the reproductive health behaviors of adolescents and young adults in the foster care system. It grew out of two previous publications from SCAA: the 2006 document Growing Up in New York: Charting the Next Generation of Workers, Citizens and Leaders, and the 2008 report, Teenage Births: Outcomes for Young Parents and Their Children. Both documents showed that youth in foster care face major challenges at the time they become sexually active.

The antecedents of sexual risk-taking appear early in life. Most children arrive in the foster care system with health, social-emotional and educational problems. Most have endured poverty and many suffer from abuse and neglect. All of these experiences greatly shape their physical and social development as well as their behavior.

While all teens exhibit risk-taking behavior, the past experiences of foster care youth make them particularly apt to engage in activity that could cause teen pregnancy and sexually transmitted diseases.

- Nearly one-third of young women in foster care reported that they had been pregnant at least once by age 17 and that number rose to almost 50% by age 19.
- About half of 21-year-old men aging out of foster care reported having gotten someone pregnant.
- Nearly one-third of youth in or transitioning from foster care had at least one child.
- Foster care has been associated with being younger at first conception and having more sexual partners.
- One study on sexually transmitted diseases (STDs) found that foster care youth had almost twice the infection rate of other youth.
- In at least one study, a high percentage of pregnant foster care youth reported that they had been the victim of forced sexual activity or other physical abuse.
Sexually active teens in the foster care system are bridging the worlds of childhood and adulthood. To help them make positive decisions, they must be re-engaged in school, involved in mentoring relationships and supported by a broad range of health and mental health services.

SCAA urges the state to create a work group to develop a plan to reduce teen births and improve outcomes for teen parents and their children with a special emphasis on the needs of high-risk foster care youth. In Teenage Births: Outcomes for Young Parents and their Children, SCAA called for such a work group made up of legislators, representatives from the Governor’s staff, agency staff and advocates.

Given the state’s budget situation it would be easy to delay efforts to address the needs of teen parents and their children. However, there are things that can be done now and it is unwise to wait. Even without new resources, the state can start to review policies, align priorities across agencies and ensure that existing efforts are being maximized. As this report will show, the needs of these young people are so great and cross so many systems that there is much to be gained through state level collaboration. The children of these young parents can’t wait—and they won’t get a second chance for a good start in life.

In addition to the work group, SCAA advocates other policy changes to improve the lives of pregnant and parenting teens in foster care. The following bullets summarize the recommendations in the areas of prevention, access to services and information:

- Provide comprehensive training to adults who work with foster care youth on the sexual risk-taking behavior found in this population.
- Ensure that all foster care teens have access to needed mental health services.
- Develop strong connections between comprehensive home visiting programs and pregnant and parenting foster care teens.
- Replicate successful models that provide an array of services for parenting teens in foster care and their children.
- Use the National Youth in Transition Database to capture needed information on pregnant and parenting youth and youth who have aged out of foster care.

Foster care is intended to be a short-term placement for children who are unable to live in their own homes with their own families. Children may be placed in foster care in cases of abuse or neglect or because of parental substance abuse or mental illness. In other cases, families may become overwhelmed by the stress of extreme poverty, mental illness or homelessness and lose their ability to provide for their children.

The traumatic events and conditions that lead children to the foster care system often mean these children have more serious physical, mental, behavioral and developmental problems when compared to children not in foster care. Many children also suffer from the experience of foster care itself. Being removed from a family, even one that is abusive, can be stressful and children who experience multiple placements can feel rejected and lost.

### The Demographics of Foster Care Youth

At the end of 2008, New York State had 25,878 children in foster care, a historically low number for the state. A slight majority was male and the second largest age cohort was 14-17 years. The largest cohort by race/ethnicity was African American. A little over half of all children lived in foster boarding homes and another quarter with approved family relatives. The rest lived in institutions, group residences and group homes.

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<th>Age</th>
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The length of a child’s foster care placement is determined by a number of factors, including whether family members are available to provide care, what investigations or court hearings find, and what progress parents make in mandated activities. It is during a foster care placement that medical providers have a chance to conduct evaluations and provide health and mental health services to children.

One longitudinal study found that most older teens in foster care entered the system during adolescence and were more likely than younger children to live in group settings than with kin or a foster family. Moreover, most older youth are either returned to their families, transferred to other child-serving systems or run away from care. Few actually stay in the system until they are too old to remain in the system, called aging out.10

The Need for Health and Mental Health Services

Children in foster care have more health and mental health problems than children generally. Most children entering foster care live in poverty, which takes a toll on health due to poor nutrition, inadequate housing and other factors. In addition, many enter the system having endured abuse and/or neglect. Some also suffer from health and developmental problems as a result of being born prematurely or with fetal alcohol syndrome.

- Approximately 50% of foster care youths have chronic medical problems unrelated to behavioral concerns.11
- 25% percent have three or more chronic medical problems.12
- The most common chronic conditions are growth failure, asthma, anemia, and neurological problems.13
- Dental problems are prevalent in children in foster care.14
- Both under-immunization and over-immunization (due to lack of medical records) are prevalent.15
- Mental health care is the most needed service for children in foster care.16 In addition to whatever mental health issues may have been present prior to placement, children in the system experience anxiety because of new living arrangements, court appearances and relationships with caseworkers and caretakers. Sadly, many youth already have behavior problems such as “attachment issues, regulatory disorders, anxiety, post traumatic stress disorder (PTSD), depression and aggression.”17 Some may mask mental health problems with substance abuse, anger and opposition.18 Others arrive after extensive interactions with the mental health system including hospitalizations, and many are already on psychotropic medication. Sometimes, children blame themselves for the loss of their family and their placement in the child welfare system.19

In the foster care system, moderate to severe mental health and behavioral problems are prevalent, with 40-60% of youth having at least one psychiatric disorder.20 Some foster care providers in New York have seen as many as 90% of the children in their care with mental health problems and express concern that the severity of mental health problems is rising.21

While children in foster care utilize mental health services at a rate 15-20 times higher than the general pediatric population,22 studies show that less than one-third of children in foster care receive needed mental health services.23 This dramatic disparity between supply and demand illustrates one of the major problems that providers face when working with this population.

A Troubled and Vulnerable Population

Youth in foster care and just leaving foster care have a particularly hard time managing the transition from adolescence to adulthood. They drop out of school at high rates, suffer from mental health problems and have high rates of unemployment, poverty and homelessness. Foster care youth also experience more negative peer interactions, conduct disorders, impulsivity and aggression than other youth.24

All adolescents take risks, but studies show that youth in foster care engage in more risk-taking behaviors than other youth.25 New research may
reveal why adolescents who’ve experienced trauma have a greater propensity for risk-taking than other kids their age.

More than ten years ago, Kaiser Permanente’s Department of Preventive Medicine and the Centers for Disease Control and Prevention (CDC) began to collaborate on what is known as the Adverse Childhood Experiences (ACE) Study. The ACE Study is the first large-scale study to demonstrate that trauma and household dysfunction in childhood significantly increase the risk for physical and mental disease in adulthood. Often, untreated abuse translates into coping mechanisms such as smoking, excess drinking, drug use, promiscuity, and overeating. The ACE data has implications for the foster care population because they have experienced both significant trauma and household dysfunction in their lives.

Teens in foster care are also vulnerable to victimization. Many have lived in environments where they either witnessed or faced physical and sexual abuse and were unable to confront or flee their assailants. Compared to other youth, young adults in foster care are almost twice as likely to have experienced forced sex. A study by Inwood House in New York City of pregnant foster care youth in their care found that nearly half (48%) reported they have been physically abused by a parent, a quarter (23%) had been physically abused by a partner or someone they were dating and more than a third (35%) reported that they had been sexually victimized.

By their teenage years, youth in foster care have lived through emotional and physical hardships that continue to impede their ability to make positive decisions and develop healthy relationships.

High-Risk Sexual Activity

Youth in foster care have significantly higher rates of sexual activity and pregnancy than their peers in the general population. Research also shows that the risk persists for youth who are transitioning out of the foster care system.

Strong family relationships can protect kids from engaging in risky behavior, including sexual activity. In fact, teens report that parents have a greater influence on their sexual behavior than either the media or peers. Unfortunately, youth who are estranged from their parents because of abuse, neglect or other trauma don’t enjoy the emotional support and guidance received by their peers with intact families.

Teens from chaotic and traumatic family environments sometimes wish to start their own families. In fact, there are many studies indicating that some “unplanned” adolescent pregnancies are actually intended with the hope of starting a new family. One study suggests that some teens do not see the potential lost opportunities if they have a child, particularly if adolescent childbearing is culturally and socially acceptable. Further, some foster care youth see having a baby as a chance to prove that they can be better parents than their parents.
The Impact of Adverse Childhood Experiences (ACE) on Sexual Behavior

Separate studies using the ACE data have found that exposure to sexual, physical abuse or domestic violence during childhood increased the risk of teenage pregnancies. This includes one study that found greater exposure to early trauma led to a greater risk of pregnancy and another that found boys exposed to abuse or who lived with a battered mother, had double the risk of impregnating a teenage girl in both adolescence and adulthood.

Sexually transmitted diseases are also a major concern for youth in foster care. ACE studies have shown that sexual abuse can increase the number of sexual partners and reduce contraceptive use. In addition, youth who encounter negative early experiences are more likely to contract an STD, have sex at an earlier age and use alcohol or drugs before sex.

Pregnancy and Parenting in the Foster Youth Population

The number of pregnant girls and teen parents in the foster care system is alarming. Although states are not required to report data on pregnancy in the foster care population, several foundation studies have begun to tease out those numbers.
Nearly one-third of young women in foster care reported that they had been pregnant at least once by age 17. By age 19 that number rose to almost 50%, with 46% reporting that they had been pregnant more than once. By comparison, only about one-fifth of their peers not in foster care had been pregnant by 19 and only 29% of those had a subsequent pregnancy. Another study found that half of 21-year-old men aging-out of foster care report having gotten someone pregnant compared to 19% of their peers.

More young women in foster care also give birth than young women not in the system. The Casey National Alumni Study of foster care youth estimated a 17.2% birth rate for girls in foster care compared to a birth rate of 8.2% for unmarried teenage women not in the system. Nearly one-third of youth in foster care or transitioning out have at least one child.

Adolescents and Sexually Transmitted Diseases

Along with pregnancy, sexual risk-taking can lead to sexually transmitted diseases. According to one national study, one in four adolescents may have a sexually transmitted disease (STD). In New York, 15 to 24-year-olds account for 14% of the population but 64% of reported STDs. Although the epidemic of sexually transmitted diseases affects a spectrum of young people, foster care youth are more vulnerable because they often lack social supports, health care and mental health counseling.

It is important for health and mental health clinicians, caseworkers and other adults in the foster care system to be concerned about the potential for teens to acquire a STD and to understand that the consequences can be serious, life-threatening, expensive and sometimes incurable. Even asymptomatic infections can cause serious health problems many years later, including cancers, infertility and AIDS. Especially troubling for girls already at risk for poor health outcomes, an STD during pregnancy can cause ectopic pregnancy, spontaneous abortions, still birth and low birth-weight babies. Babies exposed to an STD in utero or during delivery may suffer a variety of physical and developmental disabilities, including mental retardation, blindness and even death. These medical risks compound already difficult circumstances faced by a child born to a troubled teen mother.

The dangers of STDs are well illustrated by the harm that can be done by Chlamydia, the most common STD. This infection does respond to antibiotics, but, if left untreated, it can result in pelvic inflammatory disease, ectopic pregnancy and chronic pelvic pain in women and pain, inflammation and infertility in men. Exposed babies can develop blindness, joint and blood infections and other medical conditions.

This chart shows the rates of Chlamydia infection among the age cohorts in New York State. Teens (15-19) and young adults (20-24) have the highest infection rates with females having rates more than twice that of males in these age groups. Source: New York State Department of Health
Adolescents and young adults have higher STD rates than adults because they are more likely to have multiple sex partners, unprotected sex and engage in risky behaviors, such as drinking, before sex.\textsuperscript{55} STDs pose particular threats to young women both physically and psychologically. They are more susceptible to STDs because of changes in the body during puberty,\textsuperscript{56} and they often receive treatment only when the infection is advanced.\textsuperscript{57} Even girls who want to be protected may have to confront a partner’s resistance to using a condom. Negotiating this issue can be difficult for any young women, but it’s even more challenging for those with psychological problems or seeking acceptance in a relationship.

The risk-taking behaviors of foster care youth increases their chances of getting STDs compared to other youth. For example, foster care youth of both sexes are less likely than other adolescents to use contraception when they have sex for the first time.\textsuperscript{58} One study showed that almost twice as many foster care youth had an STD compared to other youth.\textsuperscript{59}
Outcomes for Young Parents

Life is hard enough for young women from disadvantaged backgrounds. Having a baby during their teen years only makes matters worse. They are more likely to receive public assistance than mothers who delay childbearing, and are less likely to complete high school or attend college.60

Teen motherhood also increases a young woman’s risk of health and mental health problems. For example, young mothers are more likely to suffer from depression. Depression can reduce their ability to form attachments with the baby and can increase stress hormones associated with lower fetal weight.61 Mothers younger than 17 are over twice as likely to have a child placed in foster care and twice as likely to have a reported case of child abuse or neglect when compared to mothers over age 20.62

A father’s involvement, or lack thereof, also affects a child’s well-being. Children with involved, caring fathers have better educational outcomes, are more likely to be emotionally secure, have better social connections with peers and are less likely to exhibit antisocial behaviors.63 Children in families with fathers are more likely to have good physical and emotional health, do well in school and avoid drugs, violence and delinquent behavior.64 Conversely, children living apart from biological fathers are more likely to live in poverty, receive welfare, drop out of high school, have children as teens, marry early and dissolve their marriages.65

Becoming an engaged, responsible father is difficult for those who are young, poorly educated, and without strong career prospects, but it is possible to improve those chances when the father is engaged during the prenatal period.66

With marriage less likely for teen parents than for older parents,67 the relationship between father and child is greatly influenced by the relationship between the mother and father. Mothers can promote the relationship between children and father or deny access to the children.

Outcomes for the Children

Children of teen mothers start life with disadvantages. They are more likely to live in poverty and suffer high rates of abuse and neglect than children born to older mothers. They are more likely to be born

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First Placement of Child in Foster Care by Age of Mother at First Birth 1982-2003

This chart shows the proportion of children placed in foster care for the first time by the age of the mother. Mothers age 15 through age 19 account for over 61% of placements. Source: Chapin Hall Center for Children
Pregnant and Parenting Foster Care Youth in New York State

Pregnant and parenting teens face huge housing challenges. They may not be welcome in their parents’ home or their partner may not want to provide assistance. For young women whose role models have poor parenting skills, the already difficult task of caring for a baby and for themselves is further complicated by the need to find a place to live. Unfortunately, there are few options specifically for pregnant and parenting teens anywhere in the country. In New York State, youth in the child welfare system may live in foster homes, group foster homes or residential facilities. Residential facilities or group foster homes are designed to provide housing for teens whose treatment needs or behaviors require a more supportive setting. A limited number of these facilities are specifically maternity residences and mother/baby homes where teens can go when they can’t stay in their existing housing.

Children and youth in foster homes receive Medicaid and receive health care services either through an agency or in the community. Maternity programs receive reimbursements for the young women in their care. Using this money, they provide housing, prenatal, health and mental health care for the mother, place the mother in school, and provide parenting and financial management classes. In addition, they make arrangements for the new mother and baby when they transition out of the program.

Unfortunately, the Medicaid reimbursement rate is too low to cover the extensive health needs foster care youth require. A related problem is the lack of pediatricians or other health care providers who accept Medicaid payments and are trained to work with adolescents who’ve had mental health trauma. Of the 62 counties in the state, 44 have less than four child and adolescent psychiatrists (CAPs), 24 have no CAPs at all and seven counties have only one CAP.

In addition, mental health providers untrained in the needs of high-risk adolescents in foster care may not be able to provide appropriate, consistent treatment as adolescents move between programs. The lack of appropriate mental health services for troubled teens is a key concern to programs since there is an increase in the severity of the mental health needs of the population entering their residences.

In addition to meeting the health needs of pregnant and parenting youth, it is critical to ensure they stay in school. This is considered one of the most important factors in their future success and the success of their children. Administrative and logistical barriers to educational continuity are a problem for agencies that serve the foster care population but provisions of the federal Fostering Connections Act (2008) should lead to some improvements. Under the Act, counties are required to have foster children remain in their school of origin where possible and coordinate with the child’s local school district to obtain records. Unless they have a medical reason, children must attend school full time.

Recently, the New York City Board of Education and the Administration for Children’s Services (ACS) signed an agreement that provides agencies with direct access to computerized school information. This allows the educational records of foster care youth to follow them through their placements and relocations.

When mothers leave foster care, the maternity program develops a discharge plan that includes housing, school (if necessary), Medicaid, WIC and other supports. However, there is no formalized structure in New York that assigns either a public or private agency to follow these new mothers or their children after they leave foster care so they can receive additional help when it becomes necessary.
prematurely and at low birth weight; both of which can lead to chronic health problems, mental retardation, cerebral palsy and other lifelong conditions. In school, they score lower on standardized tests, repeat grades more often and are less likely to complete high school.71

Unfortunately, children born to teen parents are also more likely to enter foster care or have multiple caretakers throughout their childhood.72

The Economic Costs of High-Risk Sexual Activity

Teen childbearing is expensive for all levels of government. In New York State, teen childbearing costs taxpayers about $421 million in federal, state and local dollars according to an analysis by the National Campaign to Prevent Teen Pregnancy. The analysis also estimated that the average annual cost associated with a child born to a New York mother age 17 and younger is $6,094. This number is probably conservative because it reflects public assistance, public insurance and child welfare costs but not juvenile justice, special education and other costs associated with the children of teen parents.73

One study found that the total cost of pregnancy for youth aging out of foster care is close to a quarter of a billion dollars a year nationally. If youth in foster care had just the average teen pregnancy rate, the savings would be almost $116 million a year.74

The health care system also pays the price for sexually transmitted diseases. One study in 2000 found that STDs in the 15 to 24-year-old population amount to an estimated national cost of $6.5 billion. This is because of the high incidence in this population and the high costs of certain infections, particularly HIV.75 When youth with these infections are in foster care, the costs are borne by Medicaid and other public health programs.

Promoting stability in the lives of children in the foster care system can help them develop into teens who take fewer risks. To this end, older youth, particularly survivors of abuse and neglect, must receive a range of medical and mental health supports along with education, mentoring and practical life-skills that can help them postpone parenthood or mitigate the consequences of risk-taking behavior. These interventions must help youth overcome the antecedents of teenage pregnancy: low-self-esteem, low expectations for the future, disengagement from school, growing up in poor and violent neighborhoods, lack of role models and caring relationships with adults, and lack of information about and access to birth control.76

Now, when a teen becomes pregnant those providing care must often choose from a menu of stand-alone services that neither fully meet the needs of the new mother and child nor extend over an adequate period of time. What pregnant and parenting teens require are comprehensive services that address their developmental needs as adolescents and help them prepare for the adult responsibilities of being a parent. Services that bridge these two worlds—childhood and adulthood—are few and far between.

A five-year longitudinal study conducted by Inwood House, a residential facility for pregnant and parenting foster mothers in New York City, demonstrates the importance of comprehensive interventions. The study showed that enhanced services, including intensive career training, support groups on sexual health, relationships and parenting, mentoring, expressive therapy (art, dance) and on-site educational support had a positive effect on health, mental health, employability and relationships. Young women who received these enhanced services had more family visits, an increased trust in
peers, a resume, a bank account, and a place to get information on sexual health and birth control.77

The intensity of the services also made a difference. Teens in the program that received more contact with staff, more parenting sessions and more time with mentors correlated with improvements in parental empathy, parenting expectations, parenting roles, empowerment, the quality of relationships with peers, self-efficacy to maintain safe sexual practices, and self esteem.

The benefits of the enhanced services continued as the young women transitioned out of the program. After a year, 85% had a job or were in school, 96% retained custody of their babies, and 96% had health insurance for themselves and their child. At six months, 85% reported that the father of the baby sees the baby and 100% of the babies were fully immunized against polio.

Thousands of children in New York who come from complicated home lives are well served by the people and agencies that care for them. However, there are those whose traumatic backgrounds make them much more difficult to reach. By their teen years, these children have been failed multiple times. Their development was compromised early by neglect, deprivation and insecurity that started in their own family. Then, government systems designed to identify, protect and treat children suffering both physically and emotionally were not able to give them stability. Sometimes the child welfare system itself exacerbated their problems by separating them from siblings or arranging for multiple placements. High-risk sexual activity can be viewed as one consequence of these failures, a symptom of a lifetime of unmet needs.

Recommendations

SCAA urges the creation of a state work group to develop a plan to reduce teen births and improve outcomes for teen parents and their children with a special emphasis on the needs of high-risk foster care youth. In Teenage Births: Outcomes for Young Parents and their Children, SCAA called for such a work group made up of legislators, representatives from the Governor’s staff, agency staff, advocates and successful programs. This work group should be charged with the development of quantifiable targets to reduce teen pregnancy, improve outcomes for teen births and ensure the health, education and safety of the children of teen parents. Even without new resources, the state can start to review policies, align priorities across agencies and ensure that existing efforts are being maximized.

In addition, we recommend that New York State take action in the areas of training, prevention, access to services and data collection:

• Provide comprehensive training to adults who work with foster care youth on the sexual risk-taking behavior found in this population. They should know how to access resources that will help them reduce the incidence of such behavior when working with high-risk teens.

• Ensure that all foster care teens have access to needed mental health services. Given the tremendous unmet need in this population, increasing the supply of providers must remain at the forefront of policy development. While New York State has policies to improve reimbursement and coordinate care to compensate for the current lack of providers, agencies must renew their efforts to increase the number of providers in the pipeline as quickly as possible.

• Develop strong connections between comprehensive home visiting programs and pregnant and parenting foster care teens. Comprehensive home visiting programs have been proven effective in reducing child abuse, improving health outcomes, preparing children for school, and connecting families to needed services. The New York State Office of Children and Family Services (OCFS) is working in some locations to create connections between Healthy Families New York programs and foster care agencies. This effort should designate foster care youth a priority population and standardize the process of referring teens to home visiting programs.
• **Replicate successful models that provide an array of services for parenting teens in foster care and their children.** Programs should offer health and mental health services for the mother and baby, parenting education, career training, mentoring and financial skills training. They should also assist in the transition to independence with housing and connections to social services and a strong component that follows the new family for the first few years outside foster care. Programs like the one at Inwood House represent a successful model. The state should develop an evidence-based evaluation for this type of program and a plan for replication around the state.

• **Provide sex education and access to reproductive health services, including contraceptives, to all boys and girls in foster care.** These efforts must target both sexes to reduce high-risk sexual behaviors, enable good sexual decision making and acquaint all on how to access health care.

• **Evaluate pregnancy prevention programs for their effectiveness in the foster care population.** Given their emotional, mental health and physical health needs, youth in the foster care system may require specialized pregnancy prevention programs. Models designed for foster care youth must be evaluated and replicated if found to be effective.

• **Use the National Youth in Transition Database to capture needed information on pregnant and parenting youth and youth who have aged out of foster care.** New York is scheduled to contribute to this new database in 2010 and must commit sufficient resources to ensure that the data system captures important information about pregnancy, parenting, family characteristics, and living arrangements. The information gained will be invaluable for evaluating programs, identifying gaps in services and further targeting resources for foster care youth and their children.

• **Fund pregnancy prevention and parenting programs that provide coordinated mentoring experiences.** Most of the teens in care have not had the opportunity to experience positive role models. Effective mentoring programs require staffing for recruitment, training, coordination and counseling. A small investment would improve an agency’s ability to provide teens with a rewarding mentor relationship.

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**Conclusion**

The prevalence of teen pregnancy and the dramatic increase in sexually transmitted diseases among youth are complicated public policy topics, especially when coupled with the myriad problems faced by families in the foster care system. These problems are rooted in a multitude of social ills—poverty, school failure, child abuse and neglect, and a range of health and mental health issues.

No single policy change or program will reduce pregnancies or the rate of STDs, in any group of teens, notably those in foster care, but there are a variety of steps that will make a difference over time. In the long run, helping teens in foster care prevent risky sexual behavior is not only the right thing to do, it is a cost effective way to improve their lives.

SCAA recognizes that New York is facing challenging economic times as never before. Yet, it is precisely this climate that should spur the state to action on the issues of teen births and high-risk sexual activity. The price we pay to improve the foster care and health care system to address these problems will be more than off-set by the long-term savings in public health insurance, child welfare and remedial interventions. There will also be improved revenue as the earning potential of these teens and their children increases over time. However, the system will not improve without a serious commitment on the part of government. The longer we wait, the less gain we will realize.
APPENDIX

These foster care maternity residence programs are examples of the services available in New York State.

Inwood House Maternity Residences and Family Support Programs, New York City

Established in 1830, Inwood House serves pregnant and parenting teens who are homeless, in foster care and who have aged out of foster care. Their youth development, teen pregnancy prevention and family support programs serve more than 4,000 youth and young families from 18 program sites throughout New York City and New Jersey. These young people come from some of the poorest neighborhoods in New York City with the highest incidences of teenage pregnancy and AIDS, drug abuse, school dropout and gang activity.

The research-based programs offered by Inwood House include, school and community-based teen pregnancy and AIDS prevention, education and counseling, leadership development and academic enrichment, comprehensive maternity residences for pregnant teens who are in foster care or homeless and foster family and residential care for teen mothers and their children. They also provide family support programs for mothers, fathers and their children, including maternal health education, parenting and life skills training, child care, educational guidance, computer-based family literacy, vocational and career development, housing assistance and mentoring.

In March 2009, Inwood House opened a state-of-the-art Teen Family Learning Center in Manhattan. This Center will serve as a national model of service for pregnancy and parenting teens and a training institute for best practices in teen family support, teen pregnancy, and AIDS prevention and youth development.

Community Maternity Services, Albany, New York

Community Maternity Services (CMS), an agency of Catholic Charities, provides a continuum of group home services to pregnant and parenting teenagers. Such residential services include a Maternity Home (Joyce Center), a home for mothers and children (Heery Center) and a Supervised Independent Living Program (SILP). This residential program provides comprehensive services to address the special circumstances associated with abuse/neglect, behavioral and mental health concerns and teenage pregnancy and/or parenting. Services include: group housing, 24 hour adult support/supervision, financial security, nutritional, medical and educational services, counseling, childbirth & parenting education, sexual health education, child care, employment coaching, independent living skills education, anger management training, mentoring, case management, permanency planning, crisis management, court assistance and other advocacy, assessment and referrals as needed. Interventions are designed to foster independence, provide maximum support and guidance and assist the young mother in acquiring the skills needed to provide an independent life for her and her child. Teens are discharged with an individualized, comprehensive plan.

CMS also offers community-based services that include: preventive services, parenting education, court mediation, pregnancy prevention, TASA services, respite for children with mental health issues, HIV/AIDS services, day care centers, adoption and foster care. CMS also operates a group home for children that have been removed from their home due to abuse/neglect and/or psychological, behavioral or cognitive impairment.
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