ACTIVATE | A partnership between Child Trends & Chapin Hall

Supporting the Sexual and Reproductive Health of Adolescents and Young Adults Across Systems

A Compendium of Activate Research and Practice Resources

Brittany Mihalec-Adkins & Gabriella Guerra

About the Activate Center

Young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work face unique and often overlapping challenges and needs related to their sexual and reproductive health. However, research on the sexual and reproductive health of these young people is often not easily accessible or actionable for youth-supporting professionals.

Activate translates research into resources to help youth-supporting professionals better serve these populations of young people, based on annual needs assessments (surveys and listening sessions) that identify pressing informational needs and priorities among youth-supporting professionals.

***Activate**: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals* bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

Child Trends leads Activate, in partnership with Chapin Hall. Activate is supported by a Research Alliance of researchers, youth-supporting professionals, young people, and other experts.

About the Compendium

This compendium contains Activate research summaries and practice tools published through 2026. Youth-supporting professionals who prefer to focus specifically on practical resources can also explore the companion toolkit, *A Toolkit for Supporting the Sexual and Reproductive Health of Adolescents and Young Adults Across Systems*, which includes Activate's practice tools without the research summaries.

Want more information?

Scan the QR code or visit our website, **www.activatecenter.org**, to learn more about our work, explore our full library of research summaries and practice tools, and check out the searchable Resource Explorer.

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Compendium Roadmap

This compendium organizes Activate resources into five **modules**. Each module starts with a **cover page** that previews what you'll find inside that module, as well as a **navigation matrix** that contains icons indicating the resource type, overlap with other module topics, and youth populations addressed in each resource.

The compendium is organized into five modules. Each module contains practice tools offering research-based strategies and resources to support professionals' daily practice and conversations with young people about their sexual and reproductive health.

Module 1: Data and Data Use

Resources contain key data (and data collection guidance) related to sexual and reproductive health among adolescents and young adults experiencing homelessness, involvement with the child welfare system or juvenile justice system, or disconnection from school and work.

Module 2: Healthy Relationships

Resources provide practical guidance and conversation tools to help youth-supporting professionals discuss healthy relationships, consent, boundaries, communication, peer influence, and shared power with young people.

Module 3: Violence Prevention and Intervention

Resources offer research-informed guidance for professionals working with young people at risk for experiencing workplace sex-based harassment, sex trafficking, and intimate partner violence.

Module 4: Pregnancy and Parenting

Resources address the unique experiences of young parents, with emphases on young fathers and parenthood in the contexts of child welfare or justice system involvement.

Module 5: Sexual and Reproductive Health Care

Resources include guidance to help professionals support young people's understanding of contraception options, identify barriers to sexual and reproductive health care, and connect young people to accessible, youth-centered services.

Resource Types

Research Summary | Practice Guide | Infographic | Conversation Support | Q&A Resource | Training | Tip Sheet

How to Use These Resources

The resources in this compendium provide accessible, research-informed guidance for youth-supporting professionals working to support young people's sexual and reproductive health through direct service, training, or program development and refinement. Additionally, these resources may be useful for parents, caregivers, and young people looking to know more and support health and well-being.

Below is more information about how these resources can support individuals in the following roles:

Youth-Supporting Professionals

Use these resources to stay up-to-date on research, guide sensitive conversations with young people, help young people understand their sexual and reproductive health and options, and make the most of opportunities to support young people's sexual and reproductive health and well-being.

Supervisors, Managers, and Organization Leaders

Learn more about the state of research on young people's sexual and reproductive health and well-being, incorporate these resources into staff handbooks or professional development, and use them to support staff who are navigating discussions about sexual and reproductive health with adolescents and young adults.

Policymakers

Skim these resources for a nonpartisan overview of the state of research on pressing topics related to young people's sexual and reproductive health and well-being, as well as opportunities for youth-supporting professionals and systems in your jurisdiction.

Parents and Caregivers

Gain knowledge about research on young people's sexual and reproductive health; find helpful tips for having conversations about sexual and reproductive health with the young people you love and empowering them to make informed choices related to their sexual and reproductive health and well-being.

Young People

Find helpful facts, resources, and tools related to promoting sexual and reproductive health and well-being, as well as tips and sample language to support self-advocacy in interactions with caregivers, peers, and health care providers.

Module 1: Data and Data Use

What's Inside? Resources contain key data (and data collection guidance) related to sexual and reproductive health among adolescents and young adults experiencing homelessness, involvement with the child welfare system or juvenile justice system, or disconnection from school and work.

Contents

Data on young people experiencing:

- Homelessness
- Child welfare system involvement
- Justice system involvement
- Disconnection from school and work

Research and data related to:

- Risk behaviors and sexually transmitted infections
- Contraception and pregnancy
- Sex education and health care access
- Sexual violence

Practical tools

- Infographics
- Data visualizations
- Links to practice resources
- Data collection and data use guidance

Module 1 Navigation Matrix
Data and Data Use

This matrix provides an at-a-glance overview of the resources in Module 1. Use the icons to quickly identify the resource type, overlap with other module topics, and the population(s) of young people emphasized. Click a resource title below to jump directly to that resource!

Resource Title	Topic Overlap:			Young People Experiencing...
Sexual and Reproductive Health Among Youth Experiencing Homelessness		✓	✓	✓ Homelessness
Sexual and Reproductive Health Among Youth Who Experience the Child Welfare System	✓	✓	✓	✓ Child Welfare System
Sexual and Reproductive Health Among Youth Who Experience the Justice System		✓	✓	✓ Justice System
Understanding the Sexual and Reproductive Health Among Opportunity Youth	✓	✓	✓	✓ Homelessness ✓ Disconnection
Key Data for Understanding the Sexual and Reproductive Health of Opportunity Youth		✓	✓	
Understanding the Research on STIs Among Youth Involved with Systems or Experiencing Homelessness	✓		✓	✓ Child Welfare System ✓ Justice System ✓ Homelessness
Understanding the Research on Condom Use Among Youth Involved with Systems or Experiencing Homelessness	✓		✓	
A Practical Tool for Building Data Collection and Data Use Capacity in Youth-Supporting Organizations				

Resource Types: Research Summary | Practice Guide | Infographic

Topics: Data & Data Use | Violence Prevention & Intervention | Pregnancy & Parenting | Sexual & Reproductive Health Care

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Sexual and Reproductive Health Among Youth Experiencing Homelessness

Amanda M. Griffin, Matthew Rivas-Koehl*, Katelyn Vianna Rust*, Samuel Beckwith*, Karlee Naylon*, Mindy E. Scott*, and Jan DeCoursey (**Equal contributors*)

Overview

Adolescence and the transition to young adulthood involve physical, emotional, and social changes that have implications for a young person's sexual and reproductive health. During this period, youth need youth-supporting professionals who are informed about their sexual and reproductive health. To inform youth-supporting professionals, this resource summarizes existing data about sexual and reproductive health among youth who have experienced homelessness.

Existing data analyses in this area include the following domains: sexual activity, condom and contraceptive use, sexually transmitted infections, intimate partner and sexual violence, pregnancy and parenting, sex trade, and sex trafficking. This resource first summarizes data from nationally representative samples of youth that include those experiencing homelessness. Then, it summarizes data from national and community-based samples of youth experiencing homelessness who were recruited through shelters, drop-in centers, and street outreach programs. Data from both types of samples can contribute to youth-supporting professionals' knowledge about the sexual and reproductive health of youth who have experienced homelessness.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

In addition to presenting and describing available data about sexual and reproductive health among youth who experience homelessness, each section in the summary provides high-level takeaways about the data, along with references for additional information to enhance practice. The resource concludes by highlighting the differences between findings from nationally representative samples of youth and those from community-based samples of youth. An infographic that visualizes key takeaways about youths' sexual and reproductive health accompanies this summary (*Sexual and Reproductive Health Among Youth Experiencing Homelessness*).

Sexual and Reproductive Health Data Among a National Sample of *High School Students* Experiencing Homelessness

This section focuses on a national sample of high school students experiencing homelessness.

Large, nationally representative samples that include youth experiencing homelessness allow for comparisons between youth who experience homelessness and youth who are stably housed. They also allow researchers to look for overall patterns and group differences across the whole population. The Youth Risk Behavior Survey (YRBS) is a widely known source of data based on a nationally representative sample that includes *high school students* experiencing homelessness. More specifically, the YRBS is an annual,

school-based survey of public and private high school students (grades 9–12) across the United States.[1a] Approximately 3 percent of high school students reported experiencing homelessness within the past 30 days.[2]

In this summary, we refer to the experience of homelessness based on the definition of unstable housing, which includes youth who reported sleeping in a shelter or emergency housing; in a motel or hotel; in a car, park, campground, or other public place; with a friend, family member, or other person (due to their need to leave home or because their parent or guardian could not afford housing); or not having a usual place to sleep.[3] In this summary, we used the YRBS data to estimate the prevalence of sexual activity, condom and contraceptive use, sexually transmitted infection (STI) testing, and intimate partner and sexual violence among high school students. In addition, we used YRBS data to examine differences in the prevalence of sexual activity, condom and contraceptive use, STI testing, and intimate partner and sexual violence between high students experiencing homelessness and high school students who are stably housed.

Sexual activity

Not all young people experiencing homelessness are sexually active: Slightly more than half (59.7%) of high school students experiencing homelessness reported ever having had sexual intercourse.[4] Although many youth experiencing homelessness are not having sex, high school students experiencing homelessness are more likely to be sexually active than their stably housed peers.[5]

High school students experiencing homelessness report initiating sexual activity at an earlier age and having more sexual partners than youth who are stably housed.[6,7,8] High school students experiencing homelessness are also more likely to have had sex while under the influence of alcohol or other drugs, relative to their stably housed peers.[9] Having sex while under the influence of drugs or alcohol is associated with other sexual and reproductive health behaviors, such as condom use, which have implications for unintended pregnancy and STIs among young adults experiencing homelessness.[10] Table 1 includes prevalence estimates for sexual activity.

Table 1. Sexual Activity Estimates by Housing Status

	Students Experiencing Homelessness	Stably Housed Students
Average age at first sexual experience[11]	14.2 years[€]	14.9 years
Ever had sexual intercourse[12]	59.7%[†]	33.7%
Had sexual intercourse in the last 3 months[13]	48.2%[†]	24.0%
Number of sexual partners in the past 2 months[14]	2.04[€]	1.86
Used alcohol or drugs when they last had sexual intercourse[15]	41.0%[†]	19.7%

[a] This synthesis draws on peer-reviewed publications that use data from the Youth Risk Behavior Survey across multiple years to ensure comprehensive coverage of key sexual reproductive health indictors to avoid gaps in reporting.

	Students Experiencing Homelessness	Stably Housed Students
Had four or more sexual partners during their lifetime[16]	28.0%†	6.8%

Note: [6]Indicates statistically significant difference before accounting for individual characteristics such as sex, grade level, and race/ethnicity. †Indicates statistically significant differences after accounting for individual characteristics, such as sex, grade level, and race/ethnicity.

In some instances, researchers have compared the sexual activity estimates between students experiencing homelessness and those who are stably housed. Compared to their stably housed peers, high school students experiencing homelessness were 1.7 times more likely to have ever had sexual intercourse and 1.9 times more likely to have had sexual intercourse in the past three months.[17] High school students experiencing homelessness were also 2.1 times more likely to report having used alcohol or other drugs during their last sexual encounter and 3.4 times more likely to have had four or more sexual partners during their lifetime, compared to their stably housed peers.[18, 19]

Professionals who support youth who experience homelessness can use information about youth sexual activity to consider additional ways to support these youth. For example, professionals may consider holding conversations with youth about their sexual and reproductive health needs.[a] For additional information on talking with young people about their sexual and reproductive health, please refer to the Activate resource: *6 Tips for Youth-Supporting Professionals for Talking with Youth About Sexual and Reproductive Health*.

Condom and other contraception use

Slightly more than one third of high school students experiencing homelessness reported using a condom during their most recent opposite-sex sexual encounter.[20] About one in three reported using hormonal birth control, and only a small proportion reported using both a condom and hormonal birth control.[21]

Information is limited on the factors that influence birth control use among youth experiencing homelessness. Studies involving community-based samples suggest that contraception use among women experiencing homelessness is influenced by the experiences of family and friends, the responses of their partners,[22] maintenance requirements,[23] side effects,[24] and pregnancy attitudes.[25] Table 2 includes prevalence estimates for condom and other contraception use.

Table 2. Condom Use and Other Contraception Use Estimates by Housing Status[26]

	Students Experiencing Homelessness	Stably Housed Students
Used a condom the last time they had sexual intercourse with an opposite-sex partner	37.6%†	55.1%
Used hormonal birth control the last time they had sexual intercourse with an opposite-sex partner	35.8%	34.7%
Used a condom and hormonal birth control the last time they had sexual intercourse with an opposite-sex partner	11.2%	12.1%

Note: †Indicates statistically significant differences after accounting for individual characteristics such as sex, grade level, and race/ethnicity.

High school students experiencing homelessness were 1.4 times more likely to report not using a condom than their stably housed peers.[27] However, high school students experiencing homelessness were just as likely as their stably housed peers to use hormonal birth control—either alone or in combination with condoms.[28] These similar levels of hormonal birth control use could indicate that limited knowledge about where and how to access hormonal birth control is a challenge for high school students regardless of their housing status.

For additional information about condom use among youth experiencing homelessness, please refer to the Activate resource titled: *Fact Sheet: Understanding the Research on Condom Use Among Youth Involved with Systems or Experiencing Homelessness*.

Sexually transmitted infection testing[b]

Compared to their stably housed peers, high school students experiencing homelessness were more likely to be recommended for STI/HIV testing and to have been tested for an STI or HIV when testing was recommended.[29] These testing differences could reflect that youth experiencing homelessness are connected to services (e.g., through drop-in centers) that provide access to a variety of sexual reproductive health needs such as STI/HIV testing.[30,31] However, longer periods of homelessness—and sexual behaviors such as engaging in survival sex to meet basic needs, having multiple sexual partners, substance use, and inconsistent condom use—can lead to youth experiencing homelessness becoming vulnerable to STIs.[32] Table 3 includes prevalence estimates for STI/HIV testing.

Table 3. STI or HIV Testing Estimates by Housing Status[33]

	Students Experiencing Homelessness	Stably Housed Students
Recommended for STI or HIV testing[c]	80.6%	39.9%
Had been tested for any STIs (if testing was recommended)	46.7%	22.4%
Had been tested for HIV (if testing was recommended)	41.0%	18.0%

For additional information about STIs among youth who experience homelessness, please refer to the Activate resource titled: *Fact Sheet: Understanding the Research on STIs Among Youth Involved with Systems or Experiencing Homelessness*.

Intimate partner violence and sexual violence

Intimate partner violence and sexual violence are more common among high school students experiencing homelessness than among their stably housed peers.[34] Studies using community-based samples of youth

[b] National estimates of STI and HIV prevalences are not available for youth experiencing homelessness. For consistency, we use the term STI testing throughout; however, some original resource use the term STD testing.
[c] Youth were recommended for STI testing if they were sexually active, had multiple sexual partners, used hard drugs, or were male and had sex with other males (or with both males and females).

and young adults have reported even higher rates of violence that have been linked to PTSD and drug use.[35, 36] Table 4 provides estimates of intimate partner and sexual violence by housing status.

Table 4. Intimate Partner and Sexual Violence Estimates by Housing Status

	Students Experiencing Homelessness	Stably Housed Students
Forced to have sex one or more times in their lifetime[37]	21.1%†	8.1%
Experienced sexual dating violence in the past 12 months[d38]	22.5%†	6.8%
Experienced physical dating violence in the past 12 months[e39]	23.0%†	6.2%
Experienced sexual violence in the past 12 months[40]	27.6%†	10.6%

Note: †Indicates statistically significant differences after accounting for individual characteristics such as sex, grade level, and race/ethnicity.

Compared to their stably housed peers, students experiencing homelessness were 2.6 times more likely to be forced to have sex in their lifetime, 3.1 times more likely to have experienced sexual dating violence, 3.5 times more likely to have experienced physical dating violence, and 2.6 times more likely to have been the survivors of sexual violence perpetrated by anyone.[41,42]

For answers to common questions about intimate partner violence, review the Activate resource titled: *A Research-Based Question and Answer Resource on Intimate Partner and Teen Dating Violence for Youth-Supporting Professionals*; or the TA tool titled: *How to Start a Conversation With a Young Person Who May Be Experiencing Intimate Partner Violence or Teen Dating Violence*.

Sexual and Reproductive Health Data Among *Community-Based Samples of Youth Who* Experience Homelessness

This section focuses on data analyses of select community-based samples.

Some sexual and reproductive health experiences are difficult to estimate at the national level. However, data collected from community-based samples—such as those gathered through shelters, drop-in centers, and street outreach programs—offer valuable insight into these experiences among youth experiencing homelessness. This section presents prevalence estimates of pregnancy and parenthood, engaging in sex

[d] Sexual dating violence involves any unwanted sexual activity that a young person is pressured or forced into by someone they are dating. This can include unwanted kissing or touching, or being physically forced to have sex.
[e] Physical dating violence involves being deliberately harmed by a dating partner. This may include being hit, shoved, or injured with an object or weapon.

trade, and sex trafficking from multiple studies of community-based samples of youth who experience homelessness.

Pregnancy and parenthood

Pregnancy and parenthood are common among youth and young adults experiencing homelessness. An estimated 39 percent of women 13 to 25 years old experiencing homelessness report being pregnant or having a child, and 19 percent of males 13 to 25 years old report that they were a parent or had a pregnant partner.[43] Table 5 presents findings from a brief survey administered to 4,139 unaccompanied youth and young adults ages 13 to 25 experiencing homelessness across 22 U.S. counties.[44] The majority of youth experiencing homelessness reported being in a shelter (48%), unsheltered (24%), or staying with others (24%) the night before completing the survey.[45] Findings indicate that pregnancy and parenthood rates vary significantly by age and sex.[46]

Table 5. Pregnancy or Parenting Estimates by Sex[47]

	Percent of Females Who Are Pregnant or Parenting	Percent of Males With a Pregnant Partner or Parenting
13- to 17-year-olds experiencing homelessness	10%	3%
18- to 25-year-olds experiencing homelessness	44%	18%

The prevalence of pregnancy and parenthood among youth ages 18 to 25 who are experiencing homelessness is higher compared to their stably house peers in the general population.[48] Of those who reported having a child and experiencing homelessness, 79 percent of women and 47 percent of men reported having custody of their child(ren).[49] Pregnant and parenting youth and young adults experiencing homelessness often face significant barriers to maintaining stable housing and consistent relationships with service providers.[50]

For more information on young parents who experience homelessness, review the Activate resource titled: *Exploring the Dual Experiences of Parenting While Being Parented*.

Survival sex and sex trade[f]

Engaging in survival sex—specifically, exchanging sex acts for anything required for survival, such as food, shelter, money, or other basic necessities—is a form of transactional sex that is a reality for many youth experiencing homelessness.[51] This sex occurs not by choice, but in response to extreme economic hardship.[52,53] Sex trade refers to the exchange of sexual acts for something of value, typically money, and includes a range of experiences from consensual commercial sex work to exploitative or coerced exchanges.[54] Estimates of engaging in street prostitution and survival sex among youth experiencing

[f] Sex trade and survival sex are distinct but overlapping concepts. *Sex trade* broadly refers to the exchange of sex for money, goods, or other resources and can include formal or informal forms of commercial sex. *Survival sex* specifically refers to the exchange of sex for basic needs such as food, shelter, or safety, often in contexts of limited alternatives. While not all individuals engaged in the sex trade are doing so for survival, and not all survival sex is part of the broader sex trade, the two can overlap depending on context and individual circumstances.

homelessness range from 3 percent to 46 percent.[55] Estimates range widely due to varied sample characteristics, including age and location. Table 6 presents findings from a study of 641 runaway and homeless youth ages 17 to 25 who accessed services through Covenant House's network of shelters (71%), transitional housing programs (22%), and drop-in centers (7%) at 10 sites around the U.S. and Canada.[56]

Table 6. Survival Sex and Sex Trade Estimates[57]

	Youth Experiencing Homelessness
Turned to survival sex at some point	19%
Engaged in the sex trade at some point	30%
Young men	24%
Young women	38%
Median age of entry into sex trade	18 years old
Engaged in survival sex among those who traded sex	63%

Sex trafficking

Youth experiencing homelessness are also vulnerable to becoming involved in sex trafficking. Sex trafficking is the crime of using "force, fraud, or coercion" to induce another individual to engage in a commercial sex act as defined by the Trafficking Victims Protection Act of 2000 (TVPA).[58] Minors engaging in a commercial sex act is also considered sex trafficking even if force, fraud, or coercion are not used.[59] Sex trafficking of a minor is also referred to as the commercial sexual exploitation of children. Table 7 presents estimates from the study of runaway and homeless youth who accessed services through Covenant House.[60]

Table 7. Sex Trafficking Estimates[61]

	Youth Experiencing Homelessness
Experienced being sex trafficked at some point	14%
Young men	11%
Young women[g]	20%
Median age of entry into sex trafficking	16 years old

[g] For more information on differences in sex trade and sex trafficking related to individual characteristics among youth experiencing homelessness, see: https://oag.ca.gov/sites/all/files/agweb/pdfs/ht/murphy-labor-sex-trafficking-homeless-youth.pdf

	Youth Experiencing Homelessness
Sex trafficked youth who were minors involved in commercial/survival sex without third-party coercion	42%

For answers to common questions about sex trafficking, see *A Research-Based Question and Answer Resource on Sex Trafficking for Youth- Supporting Professionals*.

Understanding Sexual and Reproductive Health Samples Sources: National vs. Community-Based Samples

This data summary provides prevalence estimates for key sexual and reproductive health experiences among youth experiencing homelessness. The data come from surveys of nationally representative samples that include students experiencing homelessness or housing instability and studies that recruited community-based samples of youth experiencing homelessness. Both sources of data can deepen our knowledge about the sexual and reproductive health of youth experiencing homelessness. However, each data source has strengths and limitations, and professionals must consider both when interpreting findings and applying them to practice.

All data must be understood in the context of how they were collected. Recognizing the strengths and limitations of each data source will help youth-supporting professions accurately interpret findings and apply them in practice.

Representative national samples allow researchers to identify trends and disparities at a population level. Table 8 summarizes the tradeoffs associated with using data derived from nationally representative samples of youth to draw conclusions about the sexual and reproductive health of youth experiencing homelessness.

Table 8. Strengths and Limitations of Nationally Representative Samples

Strengths	Limitations
✓ **Broad applicability:** Representative samples provide estimates that apply to the population. ✓ **Comparative insights:** Allow for comparisons with stably housed youth. ✓ **Trend identification:** Allow for detection of population-level patterns and disparities.	✕ **Small sample:** Youth experiencing homelessness comprise a small proportion of the total sample, which limits the ability to make group comparisons. ✕ **Exclusion of disengaged youth:** Youth experiencing or at risk of homelessness may be systematically excluded from samples. For example, student samples do not include youth who have dropped out of school and are at higher risk of experiencing homelessness. ✕ **Skewed age of sample:** Youth experiencing homelessness who are under age 18 may be overrepresented, potentially leading to lower estimates for some measures of sexual and reproductive health. ✕ **Not designed to capture homelessness:** Data do not capture the diversity of youth experiences with homelessness.

Community-based samples of youth experiencing homelessness can provide rich insights into the lives and experiences of these youth. However, these insights may not be generalizable to all youth experiencing homelessness because community-based samples are not representative. Table 9 provides a summary of the tradeoffs associated with using data derived from community-based samples to draw conclusions about the sexual and reproductive health of youth experiencing homelessness.

Table 9. Strengths and Limitations of Community-Based Samples

Strengths	Limitations
✓ **Rich insights:** Provide in-depth understanding of the lived experiences of youth experiencing homelessness. ✓ **Targeted recruitment:** Effectively reach youth through shelters, drop-in centers, and outreach programs. ✓ **More representation of subgroups**: Effectively capture p**opulations with differences in individual characteristics**, who may be more likely to access services.	✕ **Selection bias:** Findings may not be generalizable because youth disconnected from services are excluded. ✕ **Older samples:** Youth are often age 18 or older, which can lead to estimates reflecting higher rates of reporting on some sexual and reproductive health behaviors than would be expected in a younger adolescent population.[62] ✕ **Sex disparities:** Young men are more likely to be unsheltered and may be underrepresented.[63] ✕ **Small sample sizes:** Typically include fewer than 200 participants. ✕ **Geographic limitations:** Results may not apply to other jurisdictions. ✕ **Variability in experiences:** Homelessness experiences vary widely within and across samples.

Methods

We selected the sexual and reproductive health topics covered in this summary—along with the corresponding measures and data—through a multi-step process that included (1) updating a literature search to identify relevant research and resources and (2) gathering input from members of Activate's Research Alliance.

We updated a literature search conducted by the Activate team in 2021 using Academic Search Ultimate, a comprehensive EBSCO database of literature, and PubMed, a database focused on health sciences. The original search focused on the same broad topics explored in this summary and the same EBSCO and PubMed databases. We included the results of both searches in the summary.

The original search used a combination of structured search strings and database filters to identify relevant studies for this research summary. The search strings included terms related to sexual and reproductive health (e.g., "contraceptive access") and terms related to youth experiencing homelessness (e.g., "homeless," "unstably housed"). We filtered results to include only English-language publications involving United States-based samples published in peer-reviewed journals from 2011 to 2021. The updated search captured studies published since 2021.

We exported 16 potentially relevant articles that we coded from the updated search to describe the data source, characteristics of the population studied, and the measures of sexual and reproductive health that were used. We used the results of the initial coding to determine the scope of the summary. Then, the research team extracted detailed information from each article.

Collectively, the articles reviewed for this summary were published from 2010 to 2024. We prioritized more recent research (i.e., studies published since 2021), but cited studies identified as part of the original search when the more recent literature was insufficient. We also conducted supplemental searches for additional information when needed.

We solicited feedback from Activate's Research Alliance members on the literature search findings, as well as the summary's format, content, and data takeaways.

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*Authors contributed equally to conceptual development, review, and feedback on core ideas.

About the Authors

Amanda M. Griffin, PhD, is a researcher at Chapin Hall.

Matthew Rivas-Koehl, PhD, is a research scientist at Child Trends.

Katelyn Rust, BA, is a senior community liaison at Child Trends.

Samual Beckwith, PhD, is a research scientist at Child Trends.

Karlee Naylon, MPP, is a senior research analyst at Child Trends.

Mindy E. Scott, PhD, is a senior research scholar at Child Trends and the principal investigator of Activate.

Jan DeCoursey, AM, is a research scholar at Child Trends and project director of Activate.

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* indicates citations associated with data points in accompanying infographic, *Sexual and Reproductive Health Among Youth Experiencing Homelessness*

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Sexual and Reproductive Health Among Youth Experiencing Homelessness

48% of students experiencing homelessness in the past **30 days** reported being **sexually active.**

Among high school students:

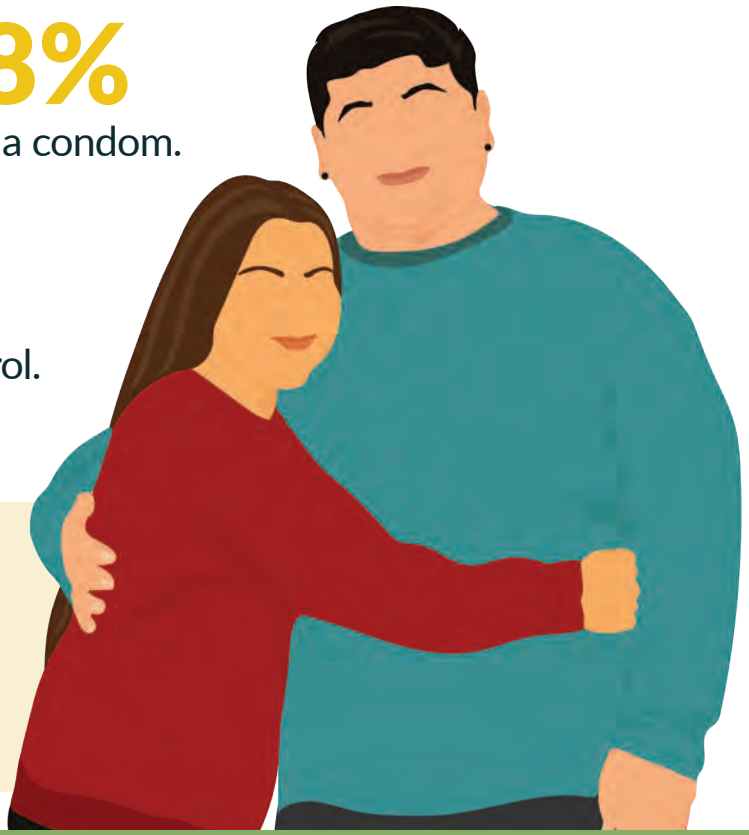
	Average age at first sex	Ever had sexual intercourse	Used alcohol or drugs during last sex
Experiencing homelessness	14.2	60%	41%
Stably housed	14.9	34%	20%

When students experiencing homelessness last had sex:

36% used a hormonal birth control.

38% used a condom.

11% used a condom and hormonal birth control.



To access the resource, associated research summary, and references, please scan the QR code or visit:
www.activatecenter.org/resource/srh-youth-homelessness

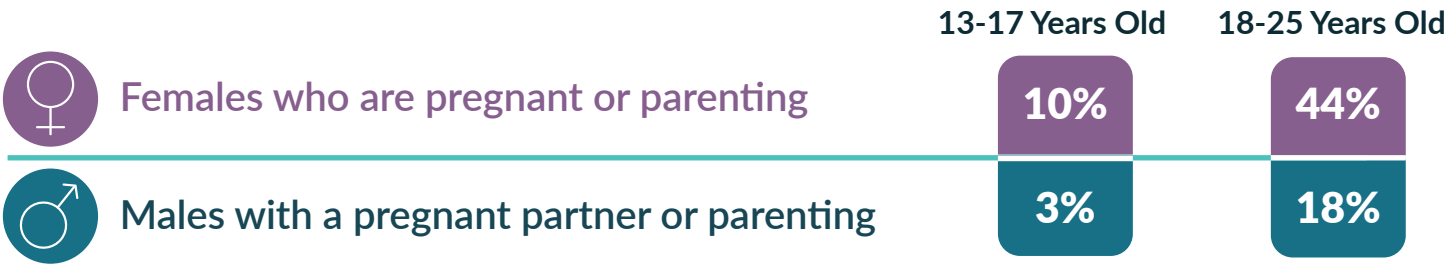
Of students experiencing homelessness:

23% experienced **sexual dating violence**

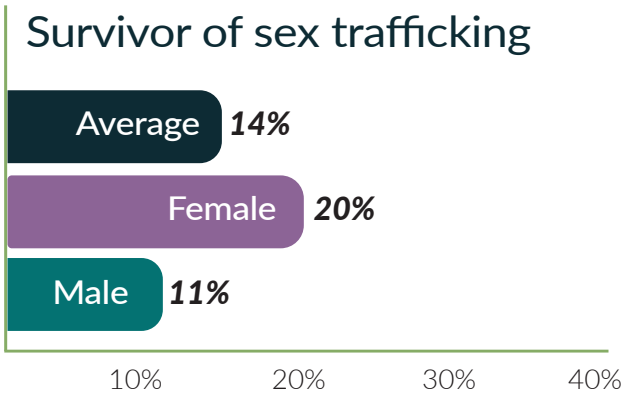
23% experienced **physical dating violence**

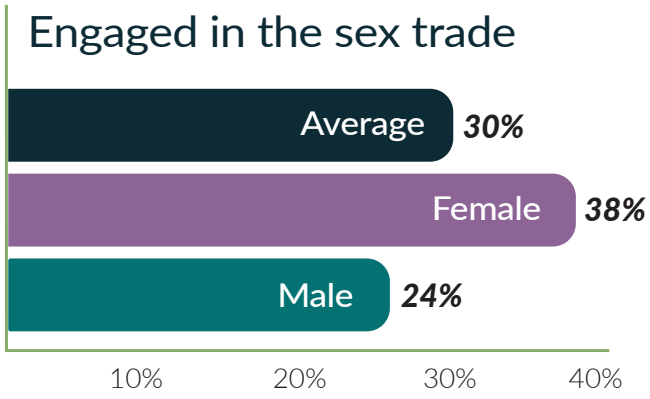
28% experienced **sexual violence**

Of pregnant and parenting homeless and runaway youth:



Of homeless and runaway youth:





Sex trafficking, a form of human trafficking, is commercial sex through force, fraud, or coercion, or involving a minor.

Sex trade is the consensual or nonconsensual exchange of sexual services for money or resources. Not all sex trade is trafficking.

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Sexual and Reproductive Health Among Youth Who Experience the Child Welfare System

Matthew Rivas-Koehl, Karlee Naylon, Jan DeCoursey, Mindy E. Scott, Samuel Beckwith*, Amanda M. Griffin*, and Katelyn Vianna Rust* *(*Equal contributors)*

Introduction

Adolescence and the transition to young adulthood involve physical, emotional, and social changes that have implications for a young person's sexual and reproductive health. During this period, youth need professionals who are informed about their sexual and reproductive health experiences. This summary, designed to inform youth-supporting professionals, describes existing research and data about sexual and reproductive health among youth who experience the child welfare system. Youth-supporting professionals may use the resource to learn about and reference information regarding the sexual and reproductive health of youth who experience the child welfare system and become more familiar with how their experiences may differ from youth in the general population.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Below, we summarize data about the sexual and reproductive health of youth who experience the child welfare system. This summary addresses the following domains of sexual and reproductive health: sexual and reproductive health education and knowledge, sexual activity, condom and other contraceptive use, sexually transmitted infections (STIs), pregnancy and childbearing, and dating and intimate partner or sexual violence. Importantly, data in this summary come from research studies that vary widely in their methods (e.g., surveys vs. interviews; one-time surveys vs. long-term studies), samples (e.g., national studies vs. studies in a single city/state), and definitions of "child welfare system experience" (e.g., foster care placement vs. history of child protective services investigations). See Table 1 for details about each study and data source used to develop this summary.

Where possible, this summary also includes estimates based on nationally representative samples from the general population. The summary concludes with considerations about the data in the summary regarding the sexual and reproductive health of youth who experience the child welfare system.

In addition to describing available data analysis about sexual and reproductive health indicators within each domain among youth who experience the child welfare system, each section of this summary provides high-level takeaways about the data and references for additional information to enhance practice. An infographic that visualizes key takeaways about youths' sexual and reproductive health accompanies this summary (*Sexual and Reproductive Health Among Youth Who Experience the Child Welfare System*).

Summary of Findings

Sexual health education and knowledge

Research suggests that youth who experience the child welfare system can benefit from sexual and reproductive health education,[1] but that less than half of these youth have received it.

- About half (49%) of one national sample of 1,093 youth ages 11 to 21 with child protective services contact had received any formal sex education.[2] In the same study, 72 percent of 433 youth ages 14 to 18 who received sex education about contraceptives/condoms knew where to access family planning services, compared to 46 percent of youth who did not receive this education. Youth who had ever been pregnant or gotten someone else pregnant were less likely to have received sex education than youth who had never been pregnant or gotten someone else pregnant.

- In a sample of 245 8th and 9th graders undergoing active child welfare system interventions (i.e., either receiving in-home services or placed in foster care), 35 percent reported ever receiving any family planning information or birth control, and 42 percent knew how to access birth control or family planning services.[3]

Professionals who support youth who experience the child welfare system can build their knowledge about—and better address—young people's sexual and reproductive health care needs by using research-based information.

Activate resources related to sexual health education and knowledge

For additional information on talking with young people about their sexual and reproductive health, please see: *6 Tips for Youth-Supporting Professionals for Talking with Youth About Sexual and Reproductive Health*.

For additional information and practice tools related to access to sexual and reproductive health care and education, please see: *Seven Dimensions of Access to Sexual and Reproductive Health Care for Youth*.

For additional information on how to assess access to sexual and reproductive health care and education in young peoples' communities, please see: *Identifying Accessible Sexual and Reproductive Health Resources in Your Community*.

Sexual activity

According to the studies included in this summary, most—though not all—young people who experienced out-of-home care were more likely than their peers in representative studies of the general youth population to report engaging in sexual intercourse by mid-to-late adolescence, being sexually active at an early age, and having more sexual partners.

Ever had sex. Most young people who experience out-of-home care have engaged in sexual intercourse by mid-to-late adolescence, according to the studies included in this summary.

- In a survey of 270 youth ages 14 to 21 who had experienced out-of-home care, 86 percent reported having had sex before age 16.[4]

- A longitudinal study of 611 California youth transitioning from foster care found that, by age 19, most (86%) had reported having engaged in sexual intercourse.[5]

Age of sexual initiation. Research suggests that many youth who experience the child welfare system may be more likely to report being sexually active at an early age, relative to the general population of youth.

- The average age at first sex among a sample of 270 sexually active youth ages 14 to 21 who had experienced out-of-home care was 13.5.[6] This study did not report on whether the sexual activity was consensual or in accordance with the legal age of consent.
- Data from the National Survey of Family Growth indicate that 16 percent of males and 11 percent of females in the general population reported having engaged in sexual intercourse by age 15, and that 55 percent of males and females reported having sexual intercourse by age 18.[7]

In a sample of over 17,000 youth who participated in the 2021 Youth Risk Behavior Survey (YRBS), 47 percent of males and 50 percent of females reported having had sex by 12th grade.[8] The same survey found that approximately 16 percent of males and 15 percent of females reported having had sex by 9th grade.

Number of sexual partners. Studies suggest that, on average, youth who experience out-of-home care have a higher number of sexual partners than youth in the general population.

- In one study, 611 youth transitioning out of foster care in California reported an average total of six sexual partners by age 19.[9]
- A sample of 228 sexually active youth ages 13 to 21 who had experienced both foster care and the juvenile justice system reported an average of 10 sexual partners.[10]

Data from about 20,000 youth represented in the 2023 YRBS indicate that just 6 percent of high school students have had four or more sexual partners.[11]

A nationally representative study found that adults with histories of adverse childhood experiences—such as abuse (physical, psychological, or sexual), neglect, or parental incarceration—reported having sex at earlier ages than adults who did not report adverse childhood experiences.[12] Youth who experience foster care generally have greater exposure to adverse childhood experiences than their peers[13]—including to adverse experiences that have been associated with early sexual activity (e.g., maltreatment, parental incarceration).[14]

With more awareness of the extent of sexual activity among young people who experience the child welfare system, professionals may want to become more informed about consent for sexual activity. Furthermore, youth-supporting professionals can use research-based, accurate, developmentally appropriate, and trauma-informed information about healthy relationships to support their work with youth. Activate has developed multiple resources (linked below) in support of these goals.

Activate resources related to sexual activity and healthy relationships

For additional information on consent for sexual activity, please see: *Seeking, Giving, and Receiving Consent for Sexual Activity*.

For practice tools related to discussing consent with young people, please see: *A Practice Guide for Understanding Consent*.

For additional information about healthy relationships among youth, please see: *Healthy Romantic Relationships and Youth Well-being*.

Condom and other contraceptive use

Studies with youth who experience the child welfare system find that slightly more than half of youth do not use condoms, mirroring data on condom use among youth in the general population.

According to several studies, youth who have experienced out-of-home care or other forms of child welfare system involvement most frequently report not using condoms at all, relative to other patterns of condom usage.

- Fifty-eight percent of a sample of 611 19-year-olds transitioning from foster care reported *not* using condoms in their most recent sexual interaction.[15]
- A study of 228 youth ages 13 to 21 who were dually involved in foster care and the juvenile justice system found that 58 percent of sexually active youth had not used condoms at all during sexual encounters in the past three months.[16]
- Forty-three percent of 18-year-olds in a nationally representative sample of 1,050 youth whose families had been investigated by child protective services reported inconsistent or no condom use.[17] This study also found that youth who reported experiencing emotional abuse were more likely to engage in sex without a condom than youth who did not report this abuse.

Of a nationally representative sample of over 17,000 high school students sampled in the YRBS, 48 percent reported not using a condom the last time they had sex.[18]

Research finds that many young people with exposure to the child welfare system report not using any form of contraception consistently – or at all. Not using contraception may be more common among youth who experience the child welfare system than among youth in the general population.

- One study found that 29 percent of sexually active youth ages 11 to 21 (37% of whom were ages 14-17; 1,093 total youth) who had contact with child protective services reported using no contraception the last time they had sex.[19]

Of a nationally representative sample of high school students in the general population, only 13 percent reported not using any form of contraception.[20]

Youth-supporting professionals who work with youth who experience the child welfare system may benefit from learning to provide research-based information and answer questions about contraceptive use. This information may help these professionals prevent both STIs and unintended pregnancies.

Activate resources related to condom and other contraceptive use

For additional information on condom use among youth who experience the child welfare system, please see: *Understanding the Research on Condom Use Among Youth Involved with Systems or Experiencing Homelessness*.

For additional information on birth control methods, please see: *Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth-Supporting Professionals*.

Sexually transmitted infections

The prevalence of sexually transmitted infections (STIs) described in the studies we reviewed indicates the importance of access to health care screenings and STI testing for young people who experience the child welfare system.

- A study of youth aging out of foster care in California found that 14 percent of 611 sexually active 19-year-olds reported ever having an STI, with reported STI rates significantly higher among females (19%) than among males (5%).[21]
- Among a sample of 437 youth ages 12 to 18 in foster care, six percent tested positive for chlamydia during clinical intake exams and 3 percent tested positive for gonorrhea.[22]
- Eight percent of females ages 13 to 17 who had experienced a child protective services investigation—including those who had also received in-home services or were placed in foster care—had been diagnosed with an STI. Specifically, 4 percent had ever been diagnosed with chlamydia, 4 percent with gonorrhea, and 3 percent with trichomoniasis.[23]

National estimates of youth in the general population suggest that up to one in four sexually active adolescents may have an STI.[24]

Professionals who support youth who experience the child welfare system can enhance their support for youth by utilizing research-based information about youths' screening and access to care for STIs.

Activate resources related to sexually transmitted infections

For additional information on STIs among youth who experience the child welfare system, please refer to the following Activate fact sheet: *Understanding the Research on STIs Among Youth Involved with Systems or Experiencing Homelessness*.

Pregnancy and childbirth

The studies we reviewed generally find that approximately one third to one half of youth who experience the child welfare system become pregnant and that approximately one third of these youth give birth. The prevalence of pregnancy and birth rates are distinct data points and different methods of measurement. We present both sets of data due to the limited available data describing these experiences.

Studies with youth who experience out-of-home care find that approximately one third to one half of youth become pregnant or get someone pregnant by their early twenties.

- In a study of 215 young people with histories of foster care placement, nearly half of young females (49%) and one in three young males (33%) reported getting pregnant or impregnating a partner by age 21.[25]
- Forty-three percent of a sample of 136 young women, ages 16 to 24, who were previously in foster care in Pennsylvania had ever been pregnant.[26]
- Among youth ages 13 to 21 with dual involvement in foster care and the juvenile justice system, 31.6 percent had ever been pregnant or gotten someone pregnant.[27]

Studies find that many youth with other exposure to the child welfare system also report experiences with pregnancy.

- Of a nationally representative sample of sexually active youth ages 11 to 21 who had contact with child protective services, 35.5 percent had become pregnant or gotten someone pregnant.[28]
- Of females ages 13 to 17 who had experience with a child protective services investigation in Wisconsin, 11.2 percent reported experiencing a pregnancy.[29]

National estimates in 2019 indicate that about 29 teens for every 1,000 in the general population would become pregnant in the United States.[30]

Two studies we reviewed described high birth rates among youth who experience the child welfare system.

- Thirty-eight percent of females who completed the National Youth in Transition Database survey had given birth by age 21.[31]
- Of a sample of 19-year-old youth transitioning from foster care in California, 49 percent of females reported ever being pregnant and 26 percent reported they had given birth.[32] By age 23, these figures increased to 67 percent and 53 percent, respectively.[33]

National estimates from youth in the general population suggest that just 6 percent of female teenagers would give birth by age 20 in 2021.[34]

Activate resources related to expectant and parenting youth

Youth-supporting professionals may benefit from a better understanding of young parents' experiences. For additional information about expectant and parenting youth, please see: *Exploring the Dual Experiences of Parenting While Being Parented*.

For additional information specifically related to expectant and parenting fathers, please see: *Understanding Young Fatherhood Within Child Welfare and Juvenile Justice Systems*.

Experiences with sexual violence and coercion

Research suggests a high prevalence of sexual violence or coercion among youth who experience the child welfare system.

Multiple studies have found that a sizable percentage of youth who experience the child welfare system also report experiencing unwanted and/or forced sex or reproductive coercion (e.g., sexual abuse, unwanted sexual advances, forced sex, teen dating violence, and/or sabotage of contraception).

- Fifty-four percent of a Midwest sample of youth ages 17 and 18 with foster care experience reported experiencing some form of physical or sexual abuse.[35]
- Thirty percent of a sample of youth ages 14 to 21 in foster care reported having experienced unwanted sexual advances, 21 percent reported having experienced forced sex, and 36 percent reported experiencing dating violence in the past year.[36]

- Among a sample of young women previously in foster care in Pennsylvania, ages 16 to 24, 30 percent reported having experienced pressure from a partner to not use birth control and/or active sabotage of contraception, such as removing or damaging contraceptives.[37]
- Forty-six percent of pregnant or parenting females who had aged out of foster care, ages 18 to 25, reported having experienced forced sexual encounters.[38]

Research suggests that many youth impacted by the child welfare system experience sexual violence and coercion. Of youth ages 10 to 18 from the Los Angeles area who had experienced out-of-home care, 11 percent reported ever being forced to have sex, 17 percent reported experiences of physical dating violence in the past year, and 7 percent reported experiencing dating-related sexual assault in the past year. Youth who experience the child welfare system investigations and/or interventions—but not out-of-home care—have reported ever experiencing forced sex (10%) and dating violence in the past year (15%) at similar rates to those who have experienced out-of-home care, but were more likely to report experiencing dating-related sexual assault in the past year (15%).[39]

These data provide context for youth-supporting professionals to understand young people's experiences of sexual violence and coercion, which may contribute to long-term symptoms of trauma.[40] Youth-supporting professionals may consider addressing the sexual and reproductive health needs of youth who have experienced the child welfare system using trauma-informed and evidence-informed approaches.[41]

Activate resources related to sexual violence and coercion

For additional information about intimate partner violence and teen dating violence, please see: *A Research-Based Question and Answer Resource on Intimate Partner and Teen Dating Violence for Youth-Supporting Professionals*.

For guidance on speaking with young people who may be experiencing intimate partner violence or teen dating violence, please see: *How to Start a Conversation With a Young Person Who May Be Experiencing Intimate Partner Violence or Teen Dating Violence*.

Research and Data Considerations

This research summary provides information about the prevalence of key sexual and reproductive health indicators for youth who have experienced the child welfare system. The data presented here come from national, regional, and community-based or program-specific samples. These data sources are valuable and can deepen our understanding of youth's sexual and reproductive health. However, each data source comes with its own considerations for interpreting research findings and applying them in practice.

See Table 1 for more information and important context regarding each study and data source referenced in this research summary.

Our review of available data also revealed several gaps in existing information, including the representativeness and relevance of the sources from which data were drawn. These gaps in the available data are highlighted below.

- **Limited recent data, especially large datasets and those that are nationally representative:** Many large datasets that describe the experiences of youth nationwide who have experienced the child welfare system are now more than a decade old. Therefore, these data may not reflect the sexual and reproductive health needs of youth today.

- **Many program- or region-specific samples:** Although datasets that are program-specific and/or region-specific provide important insights, they cannot be generalized to all youth who have experienced the child welfare system. This data summary relied heavily on data from youth in California, for example, because of the robust data collected as part of the CalYOUTH study.
- **Inconsistent definitions and measurement of key constructs:** Across studies, measures used to understand sexual and productive health are not consistent. This makes it hard to make direct comparisons between datapoints across studies and samples.
- **Heavy reliance on self-report measures: Sexual and reproductive health topics are particularly sensitive topics, and not everyone reports accurately on their experiences for a variety of reasons.** Therefore, self-reported data are biased in that they only portray what individuals remember or are willing to reveal.
- **Limited data on access to and quality of services:** There is very little available information about access to—and quality of sexual and reproductive health care received—among youth who have experienced the child welfare system. These data are important for understanding what gaps remain in youth's sexual and reproductive health care needs.

The table below provides an overview of each study or data source used to develop this summary. For each study, the table provides a full citation to the publication, a brief overview of the study, and high-level (i.e., not comprehensive) limitations and strengths of the data/study. This information is intended to help youth-serving professionals evaluate the evidence used to inform this research summary—and the evidence they use to shape their approach to working with young people.

Table 1: Sample Descriptions and Considerations for Included Studies

* indicates studies included in accompanying infographic, *Sexual and Reproductive Health Among Youth Who Experience the Child Welfare System*

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
*Ahrens, K. R., McCarty, C., Simoni, J., Dworsky, A., & Courtney, M. E. (2013). Psychosocial pathways to sexually transmitted infection risk among youth transitioning out of foster care: Evidence from a longitudinal cohort study. *Journal of Adolescent Health, 53*(4), 478–485. https://doi.org/10.1016/j.jadohealth.2013.05.010	• **Overview:** Analysis of 5 waves of data from the Midwest Evaluation of the Adult Functioning of Former Foster youth study) • **Sample:** Baseline interviews of 732 youth ages 17-18 who were in out-of-home care at age 17 and more than 1 year prior to study; wave 2-5 interviews: ages 19, 21, 23-24, and 25-26 • **Demographics:** 52% female; 57% African American, 31% White, and 12% "other" • **Data collection period:** May 2002-May 2011	• **Limitations:** Limited to the Midwestern U.S. only (Illinois, Iowa, Wisconsin); older data • **Strengths:** Longitudinal data (i.e., the same participants were followed over time); large sample

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
*Brasileiro, J., Widman, L., Norwalk, K., McCrimmon, J., & Mullins, L. (2022). National trends and disparate access to formal and informal sex education among youth involved with the child welfare system in the USA. *Sex Education, 23*(6), 723–739. https://doi.org/10.1080/14681811.2022.2134102	• **Overview:** Used data from the Second National Survey of Child and Adolescent Wellbeing (NSCAW II) • **Sample:** 1,093 youth ages 11-21, with a subsample of 433 youth ages 14-18 who provided responses to items on knowledge of where to access family planning services • **Demographics:** 44% White/Non-Hispanic, 30% Hispanic, 21% Black/Non-Hispanic, 6% Other/Non-Hispanic • **Data collection period:** August 2011-December 2012 (i.e., NSCAW II wave 3)	• **Limitations:** Self-reported measures on sensitive topics like sexual activity can be affected by social desirability bias (the inclination to respond to survey items in a way that might be viewed more favorably than others). Given the wide age range, the percent of youth who are sexually active (described in the study as having vaginal sexual intercourse) likely skews toward the higher age range. • **Strengths:** NSCAW II data are carefully sampled to ensure representation of subgroups (e.g., adolescents in foster care).
Cheung, K. K., Montgomery, D., & Benjamins, L. J. (2016). Prevalence of sexually transmitted infections among adolescents entering child protective services. *Journal of Pediatric and Adolescent Gynecology, 28*(5), 324–326. https://doi.org/10.1016/j.jpag.2014.09.011	• **Overview:** Retrospective review of medical charts from Harris County Protective Services Clinic in Houston, Texas • **Sample:** 437 youth ages 12-18 who entered state custody in Harris County and presented to CPS for an intake physical • **Demographics:** Majority female (63.2%) and African American (45.8%), and all participants reported that they were sexually active • **Data collection period:** January 2009-December 2011	• **Limitations:** Self-report data are not always reliable. • **Strengths:** Screening completeness for chlamydia and gonorrhea; the authors note that while the sample size for the study is large, only a few documented records for chlamydia and gonorrhea screenings were missing (15 of 437).

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
Combs, K. M., Begun, S., Rinehart, D. J., & Taussig, H. N. (2018). Pregnancy and childbearing among young adults who experienced foster care. *Child Maltreatment, 23*(2), 166–174. https://doi.org/10.1177/1077559517733816	• **Overview:** Eight cohorts of youth were originally enrolled in a randomized control trial studying the effectiveness of the Fostering Healthy Futures program. • **Sample:** Youth who had been living in out-of-home care within the preceding 12 months were initially recruited from ages 9-11. This study re-enrolled 209 youth ages 18-22, all from a single metropolitan area in the western United States (unspecified). Average age of participants was approximately 20. • **Demographics:** 54.1% Latino/Hispanic, 48.8% White, 28.7% American Indian, and 26.8% Black. Race/ethnic groups were not reported as mutually exclusive categories; approximately half of youth self-identified as one race/ethnicity, 30% identified as two, and 20% identified as three or more. 89% of youth self-identified as heterosexual/straight. • **Data collection period:** Eight cohorts of youth 2002-2009	• **Limitations:** Authors report some differences in participants' likelihood of reporting a pregnancy (43% of young females reported experiencing one or more pregnancies during their teenage years, compared to 27.5% of young males who reported causing a pregnancy during their teenage years). Differences between young females and young males were not found in age at first pregnancy or repeat pregnancies.
*Combs, K. M., Lee, M. C., Winter, V. R., & Taussig, H. (2022). Sexual and reproductive health protective factors among adolescents with child welfare involvement. *Children and Youth Services Review, 140*, 106593. https://doi.org/10.1016/j.childyouth.2022.106593	• **Overview:** Study data were collected as part of a study on the effectiveness of the Fostering Healthy Futures program. • **Sample:** 245 youth ages 12-15 with open child welfare cases due to maltreatment across four metropolitan counties in the United States (unspecified); nearly half of youth (45%) were living in out-of-home care. • **Demographics:** 49% Hispanic, 26% American Indian or Alaska Native, 25% Black; a slight majority of participants were female (61%) • **Data collection period:** Four cohorts over four consecutive summers from 2015-2018	• **Limitations:** Participants were from one area in the western United States. The sample also excluded some subgroups, including youth expecting or parenting a child. For these reasons, findings cannot be assumed to represent all adolescents impacted by the child welfare system.

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
*Courtney, M. E., Okpych, N. J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., & Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Foster Youth at Age 19*. Chapin Hall. https://www.chapinhall.org/research/majority-of-california-youth-in-foster-care-believe-extended-care-helps-them-reach-life-goals/	• **Overview:** Longitudinal study that follows young adults (ages 17-21) transitioning from foster care to adulthood in California • **Sample:** 611 youth age 19 who had completed a baseline interview at age 17 (see above) • **Demographics:** 47.4% Hispanic, 47% mixed race, 24% White, 18% Black; 60% female and 40% male • **Data collection period:** March 2015-December 2015	• **Limitations:** Findings may not represent the experiences of youth in other states. • **Strengths:** Large sample size helps provide robust statistics.
Finigan-Carr, N., Steward, R., & Watson, C. (2018). Foster youth need sex ed, too!: Addressing the sexual risk behaviors of system-involved youth. *American Journal of Sexuality Education, 13*(3), 310–323. https://doi.org/10.1080/15546128.2018.1456385	• **Overview:** Convenience sample of youth in Baltimore City, MD as part of studying a sexual health education curriculum • **Sample:** 270 youth ages 14-21 in out-of-home care, including foster homes, group homes, therapeutic treatment centers, and detention centers • **Demographics:** 82% African American, 7.9% Latinx, 28.0% Other; 60.7% male and 39.3% female • **Data collection period:** 2012-2016	• **Limitations:** Findings represent the experiences of youth from a particular area of the country and may not be representative of all youth who experience out-of-home care.
Finigan-Carr, N. M., Craddock, J. B., & Johnson, T. (2021). Predictors of condom use among system-involved youth: The importance of sex ed. *Children and Youth Services Review, 127*, Article 106130. https://doi.org/10.1016/j.childyouth.2021.106130	• **Overview:** Evaluation of a sexual and reproductive health education curriculum designed for system-involved youth • **Sample:** 228 youth ages 13-21 (average = 18) involved in both the foster care and juvenile justice systems in a mid-Atlantic state (unspecified) where youth can remain in child welfare until age 21. All youth reported being sexually active at baseline. • **Demographics:** 80% African American (other race/ethnicity information not reported); 63.2% male • **Data collection period:** 2012-2016	• **Limitations:** The context of dual involvement should be considered, as these youth may be at even higher risk of experiencing adverse outcomes related to the stressors and trauma of involvement in multiple systems.

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
Font, S. A., Caniglia, M., Kennedy, R., & Noll, J. G. (2022). Child protection intervention and the sexual and reproductive health of female adolescents ages 13 to 17 years. *JAMA Pediatrics*, *176*(5), 461–469. https://doi.org/10.1001/jamapediatrics.2021.6605	• **Overview:** Authors linked longitudinal statewide administrative data, including Medicaid data and CPS records from 2014-2019 • **Sample:** 9,392 female adolescents investigated by CPS for suspected maltreatment in Wisconsin prior to their 13th birthday, who were tracked from ages 13 to 17, and who received medical assistance for at least 85% of months from ages 13-18 (or end of 2019, whichever came first) • **Demographics:** 42.8% White, 26.6% Black, 16.7% Hispanic, 2.9% other (i.e., American Indian, Asian, Pacific Islander, or unknown), 10.9% multiracial • **Data collection period:** 2014-2019	• **Limitations:** Data come from a single state and a specific timeframe (birth years 2000-2002), which limits generalizability. CPS policies and Medicaid administration vary widely across states and the study sample is not representative of the entire population of female adolescents who became CPS-involved. The data overrepresent youth in foster care and adolescents receiving Supplemental Security Income disability, and underrepresent youth who lived in higher-income families who had private insurance. Authors state that STI prevalence is underestimated because of a lack of universal screening, infections that are asymptomatic, delays in testing and diagnosis, and use of medical providers that do not bill to Medicaid. They also note that pregnancies that ended in abortion or miscarriage were also likely underestimated or not captured.
Herrman, J. W., Finigan-Carr, N., & Haigh, K. M. (2017). Intimate partner violence and pregnant and parenting adolescents in out-of-home care: Reflections on a data set and implications for intervention. *Journal of Clinical Nursing*, *26*(15–16), 2409–2416. https://doi.org/10.1111/jocn.13420	• **Overview:** Descriptive study that stems from a larger study that evaluated a sexual reproductive health curriculum for youth in out-of-home care • **Sample:** 151 youth ages 14-21 in out-of-home care (including traditional foster care, kinship care, group homes, and juvenile detention centers) in an urban setting (unspecified). All youth in the sample reported being sexually active. • **Demographics:** 80% African American (other race/ethnicity information not reported); 56% male • **Data collection period:** 2012-2015	• **Limitations:** The small sample size of this study and collection of data from a single urban setting limit the generalizability of findings. The authors also note that qualitative approaches (i.e., focus groups and interviews) may provide a clearer picture of the experiences of intimate partner violence among adolescent mothers living in out-of-home care.
*Kobulsky, J. M., Villodas, M., Yoon, D., Wildfeuer, R., Steinberg, L., & Dubowitz, H. (2021). Adolescent neglect and health risk. *Child*	• **Overview:** Used data from the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN), a multi-site study in the United States that tracks children and youth at high risk for or with confirmed maltreatment • **Sample:** 1,050 youth who had direct involvement in the child welfare system	• **Limitations:** While LONGSCAN is a multi-site study with multiple regions of the United States represented, it is not a fully nationally representative study of all adolescents.

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
Maltreatment, *27*(2), 174–184. https://doi.org/10.1177/10775595211049795	and youth considered "high risk" for maltreatment based on risk factors. Participants completed a 16- and/or 18-year-old interview (note: data presented in accompanying infographic are from youths' responses at age 18) • **Demographics:** 55.7% Black, 20.4% other, 23.9% White; 53.4% female • **Data collection period:** 1991-2002	
Kobulsky, J. M., Cederbaum, J. A., Wildfeuer, R., Grest, V. C., Clarke, L., & Kordic, T. (2022). Comparing the prevalence of sexual behaviors and victimization among adolescents based on child welfare system involvement. *Child Abuse and Neglect*, *134*, 105883. https://doi.org/10.1016/j.chiabu.2022.105883	• **Overview:** Data come from LA Unified School District's 2015 administration of the Youth Risk Behavior Survey (YRBS) • **Sample:** 2,365 youth ages 10-18. The sample was disaggregated into three mutually exclusive categories: o 1,1775 youth with no child welfare involvement o 108 youth with child welfare involvement resulting in foster care placement o 129 youth with child welfare system involvement not resulting in foster care placement • **Demographics:** Across the entire sample, 70.6% Hispanic or Latinx, 33.7% White, 11.6% Black or African American, 9.2% Asian, 8.4% Native Hawaiian or Other Pacific Islander, 8.2% American Indian or Alaska Native; 51.2% female • **Data collection period:** 2015	• **Limitations:** Participants are from a single school district and findings cannot be generalized to all youth who have experienced the child welfare system.
*PettyJohn, M. E., Reid, T. A., Miller, E., Bogen, K. W., & McCauley, H. L. (2021). Reproductive coercion, intimate partner violence, and pregnancy risk among adolescent women with a history of foster care involvement. *Children and Youth Services Review*, *120*, 105731. https://doi.org/10.1016/j.childyouth.2020.105731	• **Overview:** Study sought to explore the prevalence of reproductive coercion among adolescent women currently or formerly in foster care. • **Sample:** 136 women ages 16-24 who voluntarily sought services for youth currently or formerly in foster care from youth-serving agencies in western Pennsylvania. Participating agencies included one drop-in center and four residential facilities for foster youth. • **Demographics:** 67.4% Black, 19.3% White, 13.3% multiracial/other. Only approximately half of participants described themselves as exclusively heterosexual (53.4%) and 46.6% described themselves as mostly heterosexual, bisexual, or gay. • **Data collection period:** 2015-2016	• **Limitations:** The generalizability of findings is limited by the study's small sample size and data collection in a single geographic location. Participants had also voluntarily sought services from agencies, which may have resulted in self-selection bias.

Child Welfare-Specific Studies Described in Summary		
Study	**Study Overview**	**Study Limitations and/or Strengths**
Rouse, H. L., Hurt, T. R., Melby, J. N., Bartel, M., McCurdy, B., McKnight, E., Zhao, F., Behrer, C., & Weems, C. F. (2021). Pregnancy and parenting among youth transitioning from foster care: A mixed methods study. *Child and Youth Care Forum, 50*, 167–197. https://doi.org/10.1007/s10566-020-09567-0	• **Overview:** Secondary analysis of survey and focus group data from the Youth Policy Institute of Iowa. It is unclear when the data were originally collected. • **Sample**: 81 youth ages 18-25 who had aged out of foster care at/near age 18, voluntarily enrolled in aftercare services and currently pregnant (or had birthed or fathered one or more children prior to age 21). • **Demographics:** 75.3% female; 60.5% White, 24.7% Black, 14.8% multiracial • **Data collection period:** Unclear	• **Limitations:** While findings from the study highlight the need for parenting supports among foster youth, the study sample is very small and data come from youth in one state. The findings are not generalizable to all youth who age out of foster care. This sample is also limited by the fact that all youth in the sample were pregnant, had given birth, or fathered a child by age 21. Their unique experiences may not be reflective of all youth who have experienced foster care.
Shpiegel, S., Fleming, T. P., Mishraky, L., VanWert, S., Goetz, B., Aparicio, E. M., & King, B. (2021). Factors associated with first and repeat births among females emancipating from foster care. *Children and Youth Services Review, 125*, 105977. https://doi.org/10.1016/j.childyouth.2021.105977	• **Overview:** Study utilized data from the National Youth in Transition Database (NYTD) and the Adoption and Foster Care Analysis Reporting System (AFCARS) to explore risk-, protective-, and child welfare-related factors associated with repeat births ages 19-21. • **Sample:** National sample of 3,669 females who were transitioning out of foster care and surveyed at age 21 • **Demographics:** 40.7% Non-Hispanic White, 27.3% Black, 22.1% Hispanic, 6.3% multiracial, 2.7% other • **Data collection period:** 2018	• **Limitations:** NYTD is limited in several ways:[42] o Inconsistent response rates across survey administrations o Yes/no questions provide minimal context o State-by-state differences in administration/data collection and reporting, which leads to variance in data quality o Missing data indicate that participating youth may skip questions, not complete the survey, or not participate in data collection at ages 19 and/or 21 • AFCARS data are also limited by inconsistency in reporting between states and the level of detail provided about the experiences of youth in foster care.

Methods

We selected the sexual and reproductive health topics covered in this summary—as well as the corresponding measures and data—through a multi-step process that included (1) updating a literature search to identify relevant research and resources and (2) gathering input from members of Activate's Research Alliance.

We updated a literature search conducted by the Activate team in 2021 using Academic Search Ultimate, a comprehensive EBSCO database of literature, and PubMed, a database focused on health sciences. The original search focused on the same broad topics explored in this summary and the same EBSCO and PubMed databases. We included the results of both searches in the summary.

The original search used a combination of structured search strings and database filters to identify relevant studies for this research summary. The search strings included terms related to sexual and reproductive health (e.g., "contraceptive access") and terms related to youth experiencing the child welfare system (e.g., "foster care," "out-of-home care"). We filtered results to include only English-language publications involving United States-based samples published in peer-reviewed journals from 2011 to 2021. The updated search captured studies published since 2021.

We exported 30 potentially relevant articles and coded them to describe the data source, characteristics of the population studied, and the measures of sexual and reproductive health that were used. We used the results of the initial coding to determine the scope of the summary. Then, the research team extracted detailed information from each article.

Collectively, the articles reviewed for this summary were published from 2010 to 2024. We prioritized more recent research (i.e., studies published since 2021), but cited studies identified as part of the original search when the more recent literature was insufficient. We also conducted supplemental searches for additional information when needed.

We solicited feedback from Activate's Research Alliance members on the literature search findings, as well as the summary's format, content, and data takeaways.

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About the Authors

Matthew Rivas-Koehl, PhD, is a research scientist at Child Trends.

Karlee Naylon, MPP, is a senior research analyst at Child Trends.

Jan DeCoursey, AM, is a research scholar at Child Trends and project director of Activate.

Samuel Beckwith, PhD, is a research scientist at Child Trends.

Amanda M. Griffin, PhD, is a researcher at Chapin Hall.

Katelyn Vianna Rust, BA, is a senior community liaison at Child Trends.

Mindy E. Scott, PhD, is a senior research scholar at Child Trends and the principal investigator of Activate.

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ACTIVATE

A partnership between
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Sexual and Reproductive Health Among Youth Who Experience the Child Welfare System

49% of 11-21-year olds **who experience the child welfare system** have recieved some type of sex education.

20% received sex ed on contraceptives only.

19% received abstinence-only sex ed.

10% received sex ed on abstinence and contraceptives.

42% of youth with an open child welfare case knew how to access birth control or family planning services.

To access the resource, associated research summary, and references, please scan the QR code or visit:
www.activatecenter.org/resource/srh-of-youth-who-experience-cws

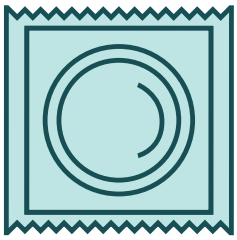
86%

Most 19-year olds who **experience foster care** have had sexual intercourse.

Among youth who experience the child welfare system:

6

On average, youth report having six sexual partners by 19.

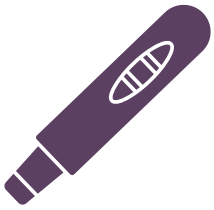


43%

of 18-year-olds report inconsistent or no condom use.

14%

of sexually active 19-year-olds reported ever having an STI.



49%

of women reported ever being pregnant by age 19.

54%

of **youth who experience foster care** reported some physical or sexual abuse.

30%

of **women ages 16-24 who experience foster care** reported pressure from a partner to not use birth control and/or their partner sabotaging their contraceptives.

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Sexual and Reproductive Health Among Youth Who Experience the Justice System

Authors: Sam Beckwith, Jan DeCoursey, Mindy E. Scott, Katelyn Vianna Rust, Matthew Rivas-Koehl*, Karlee Naylon*, and Amanda M. Griffin* (**Equal contributors*)

Introduction

Adolescence and the transition to young adulthood involve physical, emotional, and social changes that have implications for a young person's sexual and reproductive health. This summary describes existing research and data about sexual and reproductive health among youth who experience the justice system to inform youth-supporting professionals about youths' sexual and reproductive health and the health-related supports professionals may offer youth. We address the following four domains: (1) sexual activity, (2) condom use, (3) sexually transmitted infections (STIs), and (4) pregnancy and childbearing.

This research summary describes data from 16 studies of the sexual and reproductive health of youth who experience the justice system. The data are found within research studies focused on youth who are or were detained or incarcerated in a justice system facility and youth who experience justice system involvement without detention or incarceration at the time of the study (e.g., youth who have been arrested or who are or were on probation). Many studies are about youth under age 18 and are based on small, local samples rather than on large, national samples. To help contextualize these data, Appendix Table 1 provides information about the studies referenced in this summary, including information about sample size, geography, and study participant characteristics (e.g., age range, participant sex).

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

In addition to describing available data analysis about sexual and reproductive health among youth who experience the justice system, each sub-section provides high-level takeaways about the data and references for additional information to enhance practice. An infographic that visualizes key takeaways about youths' sexual and reproductive health accompanies this summary (*Sexual and Reproductive Health Among Youth Involved in the Justice System*).

Summary of Findings

In 2023, on any given day, about 22,000[a] youth under age 21 in the United States were detained or incarcerated in juvenile justice facilities.[1] For every youth whose contact with the justice system results in their detention, three more are not detained and have their cases dismissed, handled informally, or diverted

[a] This count includes youth who were in detention centers, boot camps, or long-term secure facilities. If youth in residential treatment facilities are included, the count increases to roughly 27,000 youth.

to a community-based program.[2] Additionally, approximately 180,000 young adults ages 18 to 24 are incarcerated in adult jails or prisons.[3,4] Regardless of their justice system experiences, all of these young people benefit from information about their sexual and reproductive health and from access to appropriate, youth-friendly sexual and reproductive health care services.

Sexual activity

Most youth who experience the justice system are not sexually active during their early teenage years, but they are more likely than other youth to become sexually active during those years.

In the general population of youth in the United States, it is rare to be sexually active before or during the early teenage years. In 2023, approximately 3 percent of high schoolers reported first having sex before age 13.[5] Studies have found that both female and male youth who experience the justice system were first sexually active at an early age more frequently than the general population of high school students. Further, the ages at first sex measured in several of these studies (for example, age 13) were earlier than the age of consent in most states. However, the five studies reporting age at first sex did not discuss the connections among early sex, perceived consent, legal age of consent, and abuse and neglect. Additionally, only two studies reported the exact age of the first sexual experience (the remainder reported it as above/below a particular age).[6,7,8,9,10]

The table below presents specific statistics from reviewed studies. More information about the studies, including sample sizes and participant ages, can be found in Appendix Table 1.

Studies of Detained/Incarcerated Youth	Studies of Youth with Other Justice System Involvement
• The average age at first sex among a sample of predominantly male youth in a detention facility was 13.[11] • The median age at first sex among a sample of previously incarcerated young men who had sex with women was 14.[12] • 38% of sexually active female youth in one detention facility reported having sex before age 14.[13]	• 10% of a sample of sexually active female youth with recent justice system involvement or police contact reported having sex before age 13.[14] • 75% of a sample of youth involved with both the juvenile justice and child welfare systems reported having sex before age 15, including 15% who reported having sex before age 11.[15]

Research with a representative sample of adults has found that early age at first sex was significantly more likely among those who had experienced childhood adversities such as physical, psychological, or sexual abuse; neglect; or parental incarceration.[16] Youth who experience the justice system are more likely to experience such adversities, on average, than their peers without justice system involvement.[17] Further, adolescents who experience commercial sexual exploitation or sex trafficking are more likely to be arrested than those who do not experience such exploitation.[18] While some states have laws that protect sexually exploited minors from being prosecuted for sex work-related crimes, such policies are not universal.[19] Because of this, some young victims of commercial sexual exploitation may encounter the justice system as a result of that exploitation.

The proportion of youth who experience the justice system who are sexually active increases as youth enter their mid-to-late teenage years, and many of those youth have had multiple sexual partners by their late teens.[b] Findings from several studies suggest that youth who experience the justice system have more sexual partners than the general population of high schoolers.

Studies of Detained/Incarcerated Youth	Studies of Youth with Other Justice System Involvement
• 90% to 94% of a sample of predominately male youth in a juvenile detention facility (average age of 16) reported ever having had sex and an average number of lifetime sexual partners between 9 and 10.[20] • 59% of female youth in one juvenile detention facility who had ever had sex (average age of 15) reported having had 3 or more sexual partners.[21] • The median number of lifetime female sexual partners reported by a sample of previously incarcerated (in juvenile or adult facilities) young men (median age of 20) who had sex with women was 7.[22]	• 43% of a sample of female youth (average age of 14.5) with recent juvenile justice system involvement or recent police contact reported ever having had sex.[23] • 39% of a sample of youth with first-time juvenile court involvement (average age of 14.5) reported having ever had sex, and those who had had sex reported an average of 1 partner.[24] • A sample of youth on community supervision (average age of 15) reported 4 sexual partners, on average.[25]

Although many youth involved with the justice system may have their first sexual experiences at younger ages and have more total sexual partners by their mid-teens, relative to their peers, youth involved with the justice system do not appear to have multiple recent sexual partners (i.e., within the past two or four months).[26,27,28]

Professionals who support youth who experience the justice system become more informed about youths' sexual and reproductive health when they receive more information about sexual activity. For example, professionals may consider ways to support youths' sexual and reproductive health needs and access to care.[a] For additional information, youth-supporting professionals can refer to the Activate resources: *6 Tips for Youth-Supporting Professionals for Talking with Youth About Sexual and Reproductive Health*, *Seeking, Giving, and Receiving Consent for Sexual Activity,* and *Seven Dimensions of Access to Sexual and Reproductive Health Care for Youth*.

[b] Nationally, about half of 12th graders report ever having had sex (47% of female youth, 49% of male youth). By the end of high school, 9 percent of female youth and 11 percent of male youth report having had four or more sexual partners.

Condom use[c]

In most studies, about half of sexually active youth who experience the justice system reported using a condom the last time they had sex. Studies examining condom use at last sex involved nonincarcerated samples.

Research is limited about the consistency of condom use among youth with histories of juvenile justice system contact. However, existing studies have generally found that slightly more than half of nonincarcerated youth who experience the justice system used condoms consistently and that less than half of incarcerated or previously incarcerated youth used condoms consistently.

Studies of Detained/Incarcerated Youth	Studies of Youth with Other Justice System Involvement
• Among a sample of female youth in a juvenile detention facility who reported ever having had sex, youth reported using condoms during an average of 64% of recent (past 30 days) sexual encounters.[29] • 32% of a sample of previously incarcerated (in an adult or juvenile facility) young men who had sex with women reported consistently using condoms with all partners during the previous 2 months.[30] • Reviewed studies did not examine condom use among youth who were detained/incarcerated during the last instance of having sex.	• 64% of a sample of youth reported using a condom the last time they had sex.[31] • 59% of a sample of youth with first-time juvenile court involvement reported consistent condom use (always or almost always using a condom during the past 4 months).[32] • 59% of a sample of female youth with recent justice system involvement or police contact used a condom at last sex, and 80% used some form of birth control, including condoms.[33] • 59% of a sample of youth who were involved with the juvenile court for the first time (51% of female youth and 66% of male youth) reported using a condom the last time they had sex.[34]

Youth-supporting professionals can find more information about condom use among justice-involved youth in Activate's fact sheet *Understanding the Research on Condom Use Among Youth Involved with Systems or Experiencing Homelessness*.

[c] None of the studies reviewed report the use of specific methods of hormonal contraception such as the pill, patch, shot, implant, or IUD.

Sexually transmitted infections

Current or lifetime sexually transmitted infection (STI) rates among youth who experience the justice system vary substantially across studies.

Most studies exploring STI rates or risks among youth who experience the justice system have focused on chlamydia and gonorrhea, although these youth, like all sexually active youth, are also at risk for other STIs like HIV, herpes, HPV, trichomoniasis, and syphilis. A review of STI prevalence among adolescents who were detained in the United States found prevalence rates of 8-12 percent for chlamydia, 2 percent for gonorrhea, 1-3 percent for syphilis, 0.2-0.7 percent for Hepatitis B, and 0.0-0.4 percent for HIV.[35]

Studies of Detained/Incarcerated Youth	Studies of Youth with Other Justice System Involvement
• 33% of a sample of female youth in juvenile detention who had ever had sex reported ever testing positive for an STI.[36] • 17% of chlamydia screenings and 6% of gonorrhea screenings were positive among a sample of female youth entering a juvenile correctional facility.[37] • 6% of a sample of young men in a juvenile assessment center currently had gonorrhea or chlamydia.[38] • 15% of a sample of formerly incarcerated young men who had sex with women currently had chlamydia.[39]	• 61% of a sample of youth who were arrested and referred to community-based services accepted STI screening. Of those screened, 8% tested positive for chlamydia and/or gonorrhea and 53% of those who tested positive went on to receive treatment (youth with positive tests were provided with referrals for treatment).[40] • 7% of a sample of youth on community supervision reported that they had been diagnosed with an STI, while 16% had been tested for HIV.[41]

The reviewed studies provide limited information about STI prevention or treatment. However, one experimental study engaging youth and young adults in a variety of HIV prevention interventions found that the odds of starting PrEP (pre-exposure prophylaxis, a medication that HIV-negative people may take to prevent HIV infection) were 80 percent lower for those who had ever been incarcerated than for their peers without incarceration experience.[42]

Youth-serving professionals can find more information on STIs and preventive services among youth who experience the justice system in the Activate resources *Understanding the Research on Condom Use Among Youth Involved with Systems or Experiencing Homelessness* and *Identifying Accessible Sexual and Reproductive Health Resources in Your Community*.

Pregnancy and births

Most studies indicate that at least one in 10 youth who experience the justice system will experience a pregnancy during their teenage years—a much higher prevalence than the teen pregnancy rate in the general U.S. population.

Studies of Detained/Incarcerated Youth	Studies of Youth with Other Justice System Involvement
• 26% of a sample of female youth in one detention facility who had ever had sex reported ever being pregnant (average age of 15.3).[43] • 3% of a sample of 183 female youth admitted to 17 juvenile facilities across three states were pregnant during their incarceration, with each facility admitting 0 to 6 pregnant youth each month.[44]	• 9% of a sample of youth who were involved with the juvenile court involvement for the first time reported ever being pregnant or causing a pregnancy (average age of 14.5).[45] • 32% of a sample of youth who had experienced both the child welfare and juvenile justice systems reported ever being pregnant or causing a pregnancy (average age of 17.9).[46]

Pregnant female and expectant male youth who experience the justice system may have a variety of experiences related to the intendedness, timing, or health impacts of the pregnancy or their pregnancy-related health care needs.[47] One study of pregnancy intentions found that 7 percent of youth with first-time juvenile court involvement planned to become pregnant (or cause someone to become pregnant) and thought a pregnancy was likely in the next four months; 21 percent were not planning to become (or cause someone to become) pregnant, but thought a pregnancy was likely; and 72 percent had no plans to become (or cause someone to become) pregnant and thought a pregnancy was not likely.[48]

The studies we reviewed include very little information about births among youth who experience the justice system, with one exception: **A study of high school students found that the odds of becoming a parent before age 25 were 74 percent higher for young women and 70 percent higher for young men who had ever been arrested, relative to their peers who were never arrested.**[49] This five-wave study assessed arrests, delinquency, pregnancies, births, and other experiences among teenagers in Ohio as they aged into young adulthood (up to age 25).

Youth-supporting professionals can use the Activate resource *6 Tips for Youth Supporting Professionals for Talking with Youth about Sexual and Reproductive Health* and *Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth-Supporting Professionals* for guidance on holding conversations about sexual and reproductive health. Professionals can also refer to *A Conversation Guide to Support Young Fathers in Child Welfare and Juvenile Justice Systems* to support young parents who have justice system experience.

Research and Data Limitations

Research summarized here included studies published in 2020 or later, although studies published since 2010 were included in our review process. However, some recently published studies rely on data collected several years before publication; this may limit their usefulness, as sexual and reproductive health outcomes can change dramatically over time in response to public health efforts and broader cultural trends.[50] Additionally, some sexual and reproductive health domains, such as childbearing and contraceptive use, are studied less frequently than others like condom use or age at first sex. Longitudinal studies are rare in research among youth who experience the justice system but can provide insight into complex experiences such as the transition into parenthood.

Only a small number of recent studies report data on the sexual and reproductive health of youth who experience the justice system, and existing studies have been conducted in a variety of settings and with youth who have different justice system experiences. For example, some studies focus on youth who are incarcerated, [51,52] while others focus on youth who were arrested or who had other contact with the justice system but who were not incarcerated at the time of the study.[53,54,55] A few studies involve youth who reported, as part of a larger study, that they had ever been arrested or incarcerated. [56,57,58]

The summary cites data from a variety of recent studies relying on facility-, jurisdiction-, and community-based samples of youth. Samples vary widely across studies, and each study brings strengths and limitations. Most samples are small (e.g., typically under 400 participants) and limited to a single geographic area, jurisdiction, or facility. While these studies can provide insights into the sexual and reproductive health of youth within their samples, they are not generalizable (the findings may not be broadly applicable) to all youth experiencing the justice system due to a lack of representativeness (the study participants, contexts, and other factors may not be comparable across studies). Representative national samples allow researchers to identify trends and disparities at a broader population level. However, national-level estimates are not available because none of the studies include a nationally representative sample of youth with histories of juvenile justice system involvement.

A young person's sexual and reproductive health status changes over time and may vary widely in different community or institutional contexts. Continued research is needed about the sexual and reproductive health of justice-system-involved youth in different settings, with different experiences, and from different backgrounds. Also needed are studies conducted in rural areas, studies that span jurisdictions, and studies with samples large enough to examine how sexual and reproductive health varies across groups within the overall population of justice-involved youth. Finally, researchers should apply principles of youth engagement and trauma-informed research, which can improve study rigor, enhance the utility of findings, and ensure that research activities minimize harm.[59,60,61]

Appendix Table 1. Characteristics of included studies

Study	Details
Berezin, Javdani, & Godfrey (2022)[62]	Sample of 269 female youth in the Northeastern United States who were involved in or had immediate risk of juvenile justice system involvement (i.e., recent police contact); ages 11 to 17, averaging age 14.5
Cohall et al. (2024)	Sample of 307 youth receiving community-based services following arrest in New York City; 74% male, 55% Black, 35% Hispanic, and ranging from ages 18 to 24, with an average age of 21.1

Study	Details
Crooks et al. (2023)[63]	Sample of 188 female youth in a detention facility in Atlanta, GA; 100% Black and ranging in age from 13 to 17, with an average age of 15.3; having ever had sex was an inclusion criterion
Dembo et al. (2022)[64]	Sample of 1,141 youth in a juvenile assessment center in the Southeastern United States; participants' ages ranged from 12 to 18 and the sample was mostly (78%) male
Dembo et al. (2024)[65]	Sample of 388 male youth in a juvenile assessment center in Florida; study participants were under age 18 at entry, with an average age of 15.1
Finigan-Carr, Craddock, & Johnson (2021)[66]	Sample of 228 youth involved in both the child welfare and juvenile justice settings and currently residing out of the home; 63% male, ages 13 to 21, lived in a mid-Atlantic state
Haney-Caron, Brown, & Tolou-Shams (2021)[67]	Sample of 173 court-involved but nonincarcerated youth referred from a family court in the Northeastern United States: 53% male with an average age of 15
Kim et al. (2021)[68]	Study of 17 juvenile residential facilities that housed female youth in Maryland, Georgia, and California; across these facilities, the study assessed data from 183 youth
Landeis et al. (2021)[69]	Sample of 860 youth in Toledo, OH who were followed from high school to age 25; of this broader sample, 23.4% (women) and 41.5% (men) reported ever being arrested; this summary focuses on the findings for the subsample who were ever arrested
Logan-Greene et al. (2021)[70]	Same sample as Crooks et al. (2024)
Neeki et al. (2020)[71]	Analyzed data from female youth ages 12-18 who entered a juvenile correctional facility in San Bernardino County, CA; in 2016 (the study's latest year), 382 screenings were performed.
Rosen et al. (2022)[72]	Sample of 288 youth who recently had their first contact with a large juvenile court in the Northeastern United States: 55% male, ages 12 to 17, average age of 14.5
Schmiege et al. (2021)[73]	Sample of 413 youth in a detention facility in the Southwestern United States (73-77% male, average age 15.8-15.9), as well as 124 youth in a court-ordered day program in the same region (historical control; 67% male, average age 16.1).
Stapleton et al. (2023)[74]	Sample included 1,907 Black male youth and young adults (ages 15-24) in New Orleans, LA; of this broader sample, 351 reported ever being in jail

Study	Details
Swendeman et al. (2024)[75]	Sample of 895 youth and young adults ages 12-24 located in Los Angeles, CA and New Orleans, LA; of this broader sample, 16% reported ever being incarcerated; study sample was in a broader study of HIV prevention interventions; please see the study text for more information about its sample
Wendt et al. (2022)[76]	Sample of 269 male youth in juvenile justice facilities in Oregon; average age of 17 with an age range of 14 to 19

Methods

We used a multi-step process to select the sexual and reproductive health topics covered in this summary along with corresponding data. Our process included (1) updating a literature search to identify relevant research and resources and (2) gathering input from members of Activate's Research Alliance.

We updated a literature search conducted by the Activate team in 2021 using Academic Search Ultimate, a comprehensive EBSCO database of literature, and PubMed, a database focused on health sciences. The original search focused on the same broad topics explored in this summary and the same EBSCO and PubMed databases. We included the results of both searches in the summary.

The original search used a combination of structured search strings and database filters to identify relevant studies for this summary. The search strings included terms related to sexual and reproductive health (e.g., "contraceptive access") and terms related to youth experiencing the justice system (e.g., "homeless," "justice-involved"). We filtered results to include only English-language publications involving United States-based samples published in peer-reviewed journals from 2011 to 2021. The updated search captured studies published since 2021.

We exported 39 potentially relevant articles. We then excluded five articles because they were off-topic or based on data collected outside of the United States. Altogether, we coded 34 articles from the updated search to describe the data source, characteristics of the population studied, and the measures of sexual and reproductive health that were used. We used the results of the initial coding to determine the scope of the summary. Then, the research team extracted detailed information from each article. This summary draws on a subset of 16 articles that provided relevant data on sexual and reproductive health topics of interest.

Collectively, the articles reviewed for this summary were published from 2010 to 2024. We prioritized more recent research (i.e., studies published since 2021), but cited studies identified as part of the original search when the more recent literature was insufficient. We also conducted supplemental searches for additional information when needed. For example, we conducted a supplemental search about health insurance coverage and its implications for sexual and reproductive health. In some instances, we include data from reports that are not published in peer-reviewed journals.

We solicited feedback from Activate's Research Alliance members on the literature search findings, as well as the summary's format, content, and data takeaways.

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About the Authors

Sam Beckwith, PhD, is a research scientist at Child Trends.

Jan DeCoursey, AM, is a research scholar at Child Trends and project director of Activate.

Mindy E. Scott, PhD, is a senior research scholar at Child Trends and principal investigator of Activate.

Katelyn Vianna Rust, BA, is a senior community liaison at Child Trends.

Matthew Rivas-Koehl, PhD, is a research scientist at Child Trends.

Karlee Naylon, MPP, is a senior research analyst at Child Trends.

Amanda M. Griffin, PhD, is a researcher at Chapin Hall.

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ACTIVATE | A partnership between Child Trends & Chapin Hall

Sexual and Reproductive Health Among Youth Who Experience the Justice System

Childhood adversities like abuse and neglect are associated with early sexual activity.

Justice-involved youth are significantly more likely to experience these adversities than their non-justice-involved peers.

Of youth in detention ages 14-18

90% *Reported ever having sex*

13 years *Average age at first sex*

Of youth with other justice system involvement

39% *Reported having sex* (ages 12-17)

10% *Had sex before age 13* (sexually active girls ages 11-17)

Average number of partners among youth who experience the justice system

Youth in a detention facility (ages 14-18)

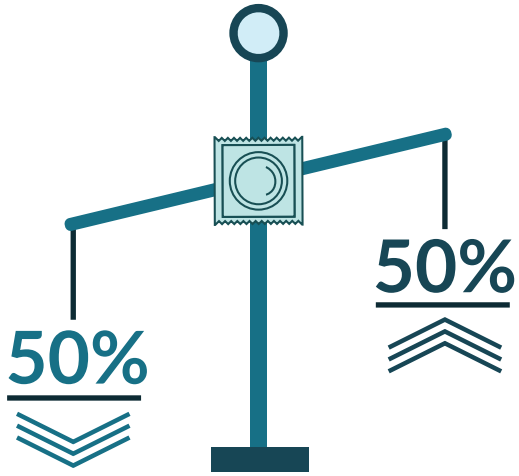
9-10 partners

Youth on community supervision (ages 12-18)

4 partners

To access the resource, associated research summary, and references, please scan the QR code or visit:
www.activatecenter.org/resource/key-data-srh-of-justice-system-involved-youth

Less than half of youth who experience incarceration consistently use condoms.



More than half of nonincarcerated justice-involved youth consistently use condoms.

A review of STI prevalence among detained adolescents found prevalence rates of

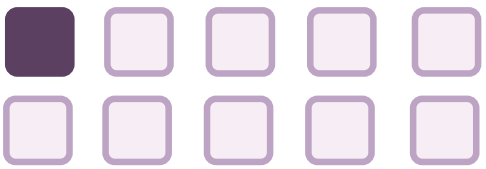
8-12% chlamydia

2% gonorrhea

1-3% syphilis

Pregnancy and childbearing among young people who experience the justice system

Young people who are arrested are **significantly more likely** to have a child by age 25



At least **1 in 10** young people who experience the justice system will experience teen pregnancy

Suggested citation: Beckwith, S., Rivas-Koehl, D., DeCoursey, J., Griffin, A., Naylon, K., Rivas-Koehl, M., Rust, K., & Scott, M. E. (2025). *Sexual and Reproductive Health Among Youth Who Experience the Justice System.* Child Trends.

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Understanding the Sexual and Reproductive Health of Opportunity Youth

Kate Welti, Samuel Beckwith, and Kelly Murphy

Introduction

Opportunity youth are young people ages 16 to 24 who are neither working nor enrolled in school. Disconnection from school and work during emerging adulthood can have long-term, negative consequences for the well-being of young people, including lower educational attainment and earnings.[1] Most research examining the consequences of disconnection has focused on young people's education and employment outcomes, resulting in a limited understanding of how disconnection affects development in other domains, including sexual and reproductive health (SRH). In particular, there are no studies on the SRH outcomes of opportunity youth in the United States based on nationally representative samples.

We addressed the gap in information about the SRH of opportunity youth by conducting an original analysis of data from the 2011-2019 National Survey of Family Growth (NSFG), the findings from which are presented in this brief.[a] Our analysis focused on:

- The demographic characteristics of opportunity youth[b]
- Factors that can influence both disconnection and SRH for opportunity youth
- SRH behaviors and outcomes of opportunity youth

Activate: The Collective to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals aims to bridge the gap between research and practice in support of the Office of Population Affairs' mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating research-based resources for use by professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Findings

In 2015, 14 percent of youth ages 16 to 24—or 5.1 million youth—were disconnected from both school and work. This estimate is in line with other published estimates of the size of the opportunity youth population for the same time period,[2] and with more recent analysis[3] of other, newer nationally representative data sources.

[a] When weighted, population estimates from the NSFG 2011-2019 are representative of 2015.
[b] For this analysis, we defined opportunity youth as young people, ages 16 to 24, who were not enrolled in school and not working in the past week. Youth who were not enrolled in school and indicated they were "not working but looking for work," "keeping house," "caring for family" and "other" were considered opportunity youth. Those who were on vacation from school or on temporary leave from work due to family leave, vacation, strike, or illness were not considered opportunity youth. Additionally, those who were married with one or more children in the household were not considered opportunity youth.

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Characteristics of opportunity youth

Just over half of opportunity youth are female (52%).

Most opportunity youth are over 18 (80%).

Most opportunity youth live with at least one parent. Eighty-seven percent of opportunity youth ages 16 to 18 and 55 percent of opportunity youth ages 19 to 24 live with a parent.

Nearly half of opportunity youth are non-Hispanic White (49%), nearly one in five (19%) are non-Hispanic Black, and approximately one in four (24%) are Hispanic. The remaining 8 percent identify as another race.

Fourteen percent of opportunity youth identify as lesbian, gay, bisexual, or "something else," compared to 10 percent of their peers who are in school or working.

Opportunity youths' experiences linked to adverse sexual and reproductive health outcomes

Experiences such as economic stability, health care and education access and quality, neighborhood and built environment, and social and community context—affect individuals' health and quality-of-life outcomes.[4] These experiences can affect both the likelihood that young people will experience disconnection from school and work and their sexual and reproductive health.

More than four in 10 opportunity youth live in poverty. Forty-two percent of opportunity youth reported living in households with an income below the federal poverty line. An additional 31 percent live in households with an income 100 to 249 percent of the federal poverty line.

Opportunity youth have different levels of educational attainment. Nearly one quarter (21%) of opportunity youth did not finish high school, about one in four (39%) have a high school degree, and the remaining 39 percent have completed some college or higher education. This distribution varies by age: 44 percent of opportunity youth ages 16 to 18 had not finished high school, compared to 16 percent of those ages 19 to 24. This suggests the possibility of important differences between opportunity youth by age, as the younger group of opportunity youth are much more likely to become disconnected prior to completing high school.

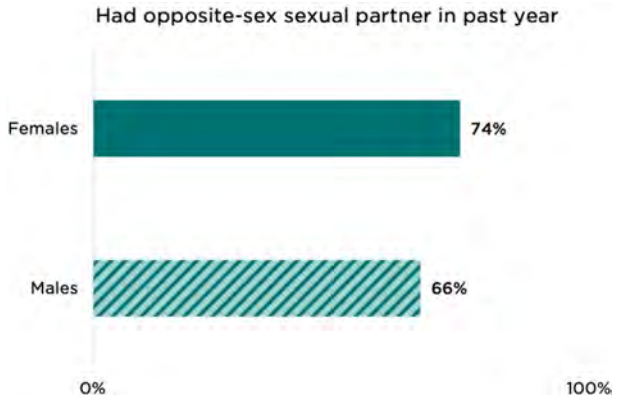
More than one in 10 opportunity youth experience food or housing insecurity. Eleven percent of opportunity youth reported that they or someone in their household experienced hunger in the past year because they could not afford food. Additionally, 15 percent reported having insecure housing—that is, they lacked a permanent place to stay for at least one night in the past year.

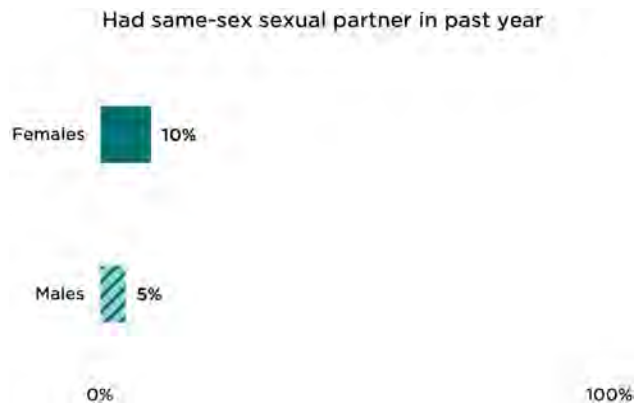
Nearly three quarters of opportunity youth had consistent health insurance and a regular place to go for medical care. Despite being disconnected from school and work, 71 percent of opportunity youth had health insurance in every month of the past year. Additionally, 71 percent reported that they had a regular place to go for medical care. This suggests that one way to reach opportunity youth is through their regular health care providers. However, having a regular place for medical care is related to health insurance status. Among those with consistent insurance, 77 percent reported having a regular place for medical care. Meanwhile, 57 percent of those without consistent insurance coverage had a regular care provider.

Opportunity youth exhibit a range of sexual and reproductive health behaviors and outcomes

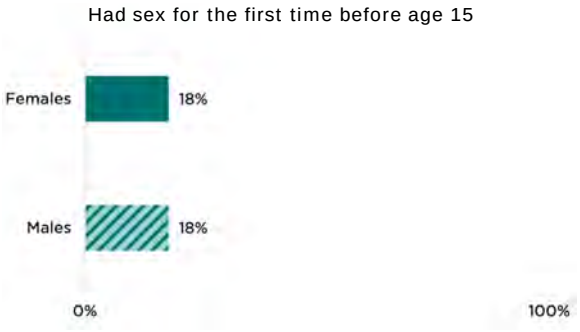
Understanding the current sexual and reproductive health behaviors of opportunity youth, as well as their SRH histories, can help professionals better serve young people who are disconnected from school and work. Because the SRH outcomes of male and female youth can differ greatly, we present findings separately for male and female opportunity youth. We also highlight notable differences between opportunity youth and their more connected peers (i.e., youth who are either enrolled in school and/or working).

Most opportunity youth are sexually active. Around three quarters of female opportunity youth (74%) and two thirds of their male counterparts (66%) had an opposite-sex partner in the past year. Fewer had a same-sex partner (10% of females and 5% of males).

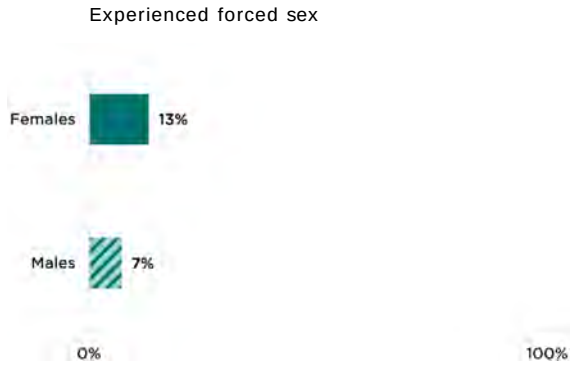




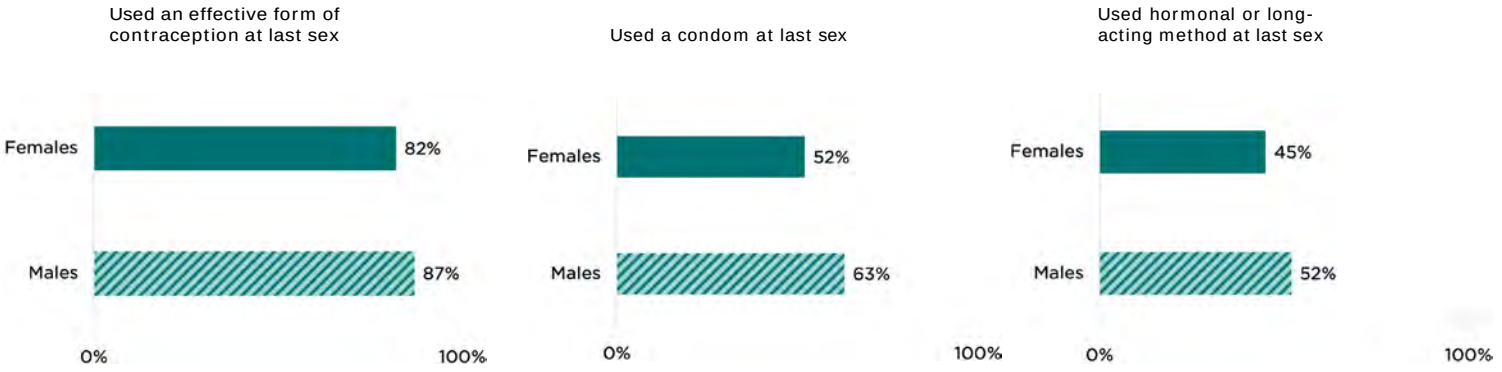
Nearly one fifth of opportunity youth experienced early sexual activity. Eighteen percent of male and female opportunity youth engaged in early sexual activity—defined as having sex before age 15. In comparison, 12 percent of youth (10% of females and 14% of males) who are enrolled in school or working engaged in early sexual activity (not shown).



About one in 10 opportunity youth have experienced forced sex. Thirteen percent of female opportunity youth and 7 percent of their male counterparts reported an experience with forced sex. We note that our analysis, based on available data, may miss youth who have had unwanted sexual experiences. This is particularly true for female youth, as the NSFG only asks female respondents about forced vaginal intercourse with a male partner.[c]



Contraceptive use is high among opportunity youth. More than 8 in 10 opportunity youth who were not pregnant (or did not have a pregnant partner) and were not seeking to become pregnant used an effective form of contraception the last time they had sex (a condom and/or a hormonal or long-acting method).[d] Approximately half (52%) of female opportunity youth and 63 percent of male opportunity youth reported using a condom the last time they had sex. Less than half of female opportunity youth (45%) reported using a hormonal or long-acting method at last sex, compared to 54 percent of their more connected peers. About half of the male opportunity youth (52%) reported that their female partner had used a hormonal or long-acting method.

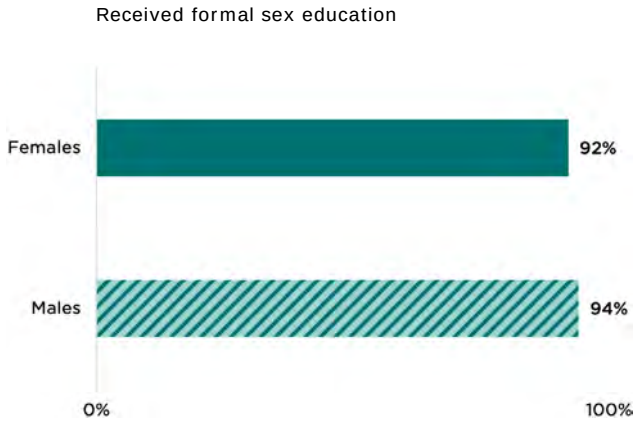


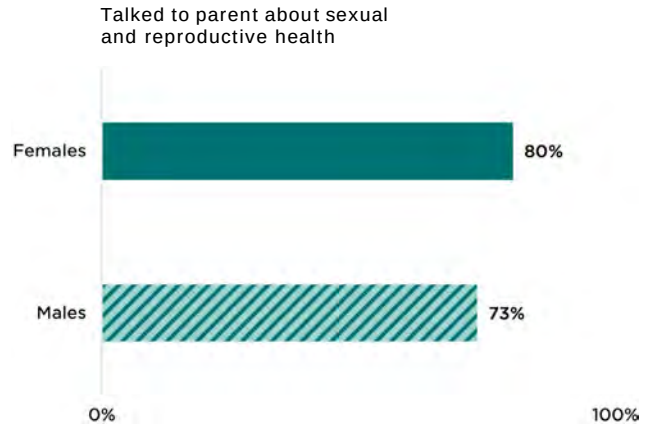
Most female opportunity youth access sexual and reproductive health services. Nearly seven in 10 (69%) female opportunity youth reported receiving SRH services in the past year (not shown). These services could include gynecological services, a birth control method or counseling, sexually transmitted infection (STI) testing or treatment, pregnancy testing, and other common reproductive health services from a private doctor or family planning clinic.[e]

[c] This measure is limited to respondents ages 18 and older. For female respondents, forced sex refers to forced vaginal intercourse with a male partner. For male respondents, forced sex could include being forced to have vaginal sex with a female or anal or oral sex with a male.
[d] Youth who had sex with an opposite-sex partner in the last year were included in this analysis.
[e] We do not have a comparable measure of SRH care for males.

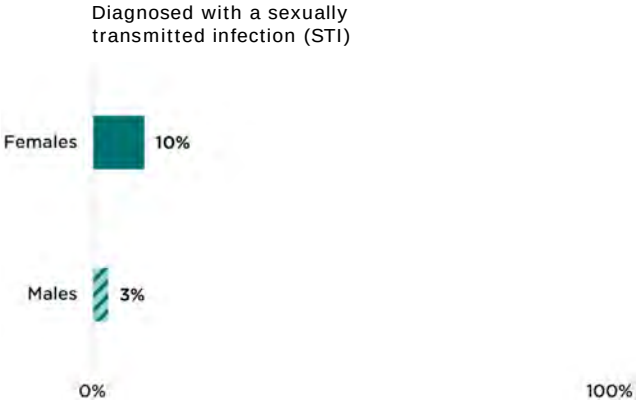
As noted above, most opportunity youth have access to insurance and a regular health care provider, indicating that many can be (and are being) served through the health care system. However, compared to female opportunity youth with consistent health insurance, those who lacked insurance at some point during the past year had a lower likelihood of accessing SRH services (65% versus 70%) and using a hormonal or long-acting method at last sex (35% versus 48%).

Most opportunity youth have received formal and informal sex education. Despite their current disconnection from school and work, the vast majority of opportunity youth (over 90%) reported receiving comprehensive sex education in school or a community setting before age 18. Additionally, 80 percent of female opportunity youth and 73 percent of their male counterparts have talked to their parents about SRH topics such as STIs/HIV, how to use a condom, and where to get birth control. As we described previously, many opportunity youth (particularly those ages 18 and younger) live with a parent, suggesting that one key way for youth-serving professionals to reach these youth may be through their families.

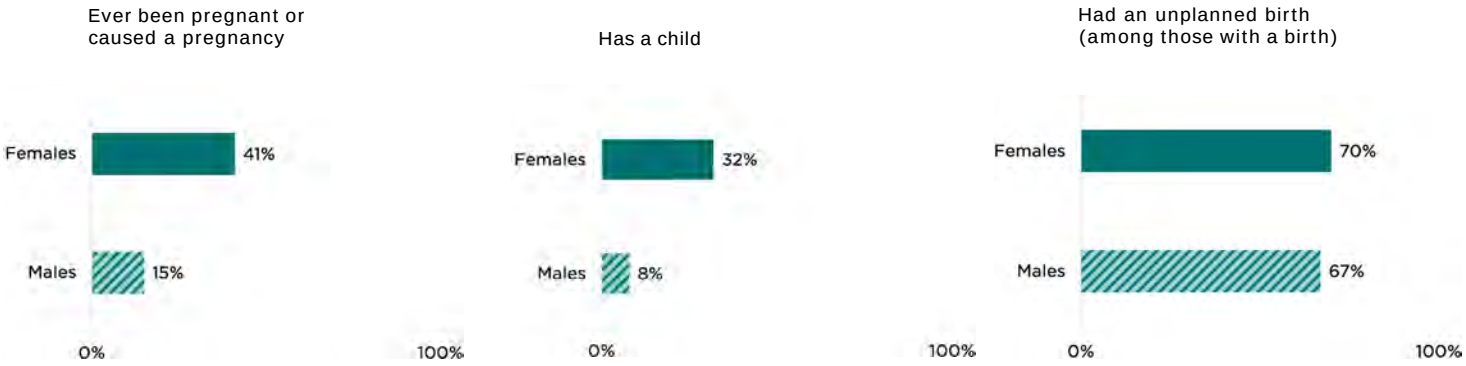




STI diagnosis is not common among opportunity youth. Ten percent of female opportunity youth and three percent of their male counterparts reported ever being diagnosed with herpes, syphilis, or genital warts, or having been diagnosed with gonorrhea or chlamydia in the past year. These rates are comparable to those seen among youth who are enrolled in school or working. (However, we note that measures of STI diagnosis can be incomplete since youth who are not tested cannot be diagnosed.)



Pregnancy and parenthood are common among female opportunity youth. Forty-one percent of female opportunity youth reported ever being pregnant and nearly one third (32%) reported having given birth.[f,g] By contrast, their more connected peers reported rates of 20 percent and 14 percent, respectively. Fifteen percent of male opportunity youth reported ever causing a pregnancy and 8 percent reported having fathered a child. The majority of both female and male opportunity youth who had given birth or fathered a child reported that at least one birth had been unplanned (70% of females and 67% of males).[h]



Although we do not know whether the opportunity youth in our analysis were disconnected from school and work prior to giving birth, three quarters (74%) of female opportunity youth with a child first gave birth two or more years prior to the survey. This indicates that having a child may have led to their leaving school or work (rather than the other way around). Other research has highlighted the challenges that young parents—especially mothers—face in trying to remain connected to school and work, including a lack of reliable and affordable child care.[5]

Summary and Implications

Findings from our analysis highlight several important things to know about the SRH of opportunity youth:

- Much like their more connected peers, most opportunity youth are sexually active, use effective contraception, and have received formal or informal sex education. Additionally, the majority of female opportunity youth access SRH care services.
- Female opportunity youth are more than twice as likely as their more connected peers to have experienced a pregnancy and to have a child. This points to the need for policies and programs to help young parents complete their education or obtain and maintain employment.
- Opportunity youth have diverse experiences and may need different types of support.
    - Youth who live in households with lower incomes and/or those who lack health insurance may experience more financial barriers to accessing SRH care.
    - Opportunity youth who are parenting have unique barriers to accessing health care (such as lack of child care or stigma from providers) but may have access to other support services.
- Future research should explore how SRH outcomes may be different for subgroups of opportunity youth (e.g., youth living in poverty, young parents).

[f] Research has found that pregnancies that do not end in birth are underreported in the NSFG, so the incidence of pregnancy could be higher than estimated.
[g] As noted in the Methods box below, respondents who were not enrolled or working but were married with a young child were excluded from the sample of opportunity youth. This approach follows as closely as possible other U.S. research on opportunity youth.
[h] A birth is considered unplanned if the respondent reported that the pregnancy was unwanted, occurred too soon, or was mistimed.

Methods

For this brief, we analyzed data from the 2011-2019 National Survey of Family Growth (NSFG), a nationally representative survey of civilian, noninstitutionalized men and women of reproductive age (ages 15-49) in the United States. Across the nine years of pooled survey data, 12,843 respondents were ages 16 to 24 and 2,049 of those respondents met our criteria for opportunity youth: not enrolled in school and not working in the past week. This includes young people who were "not working but looking for work," "keeping house," "caring for family" and "other." It did NOT include young people who were on vacation from school or on temporary leave from work due to family leave, vacation, strike, or illness. Additionally, young people who were not enrolled in school or working but were married with one or more children in the household were not considered opportunity youth. Our methodology followed as closely as possible the definition used by the Congressional Research Service (among others).

Analyses were completed in Stata 16.1 and person-level 2011-2019 survey weights were applied to produce nationally representative estimates analogous to the year 2015. A limitation of our analysis is the use of cross-sectional data, which cannot be used to disentangle the likely bidirectional associations between life experiences, opportunity youth status, and SRH outcomes such as pregnancy and parenthood. Future research should explore these factors longitudinally to better understand how they influence one another.

Endnotes

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Key Data for Understanding the Sexual and Reproductive Health of Opportunity Youth

Opportunity youth are young people ages 16 to 24 who are not working nor enrolled in school. They are a diverse group who come from different backgrounds, races/ethnicities, and communities and who have varying strengths, resources, and needs. This infographic highlights key findings from Activate's analysis of the sexual and reproductive health (SRH) of opportunity youth using the National Survey of Family Growth. Learn more through Activate's research brief, "Understanding the Sexual and Reproductive Health of Opportunity Youth."

Sexual and Reproductive Health Outcomes

Much like their connected peers (who are in school and/or working), most opportunity youth are sexually active.

Were sexually active in the past year

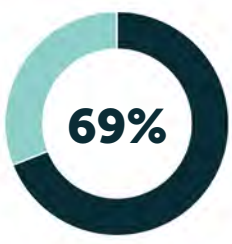
Had an opposite sex partner

Had a same sex partner

Most opportunity youth use effective contraception and the majority of female opportunity youth access sexual and reproductive health care services.

Sexually active opportunity youth who used a condom and/or hormonal/ long-acting contraceptive the last time they had sex

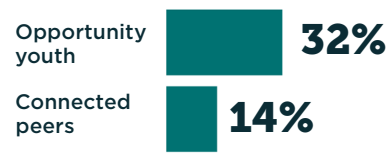
Female opportunity youth who accessed SRH services in the past year



Female opportunity youth are more than twice as likely as their connected peers to have experienced a pregnancy and to have a child.

Ever been pregnant

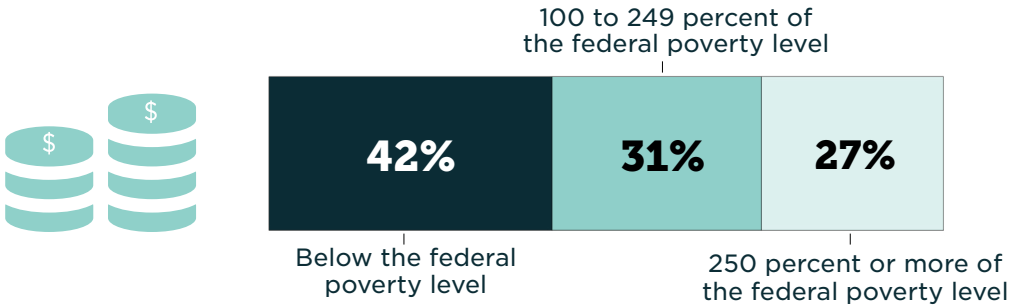
Have a child*



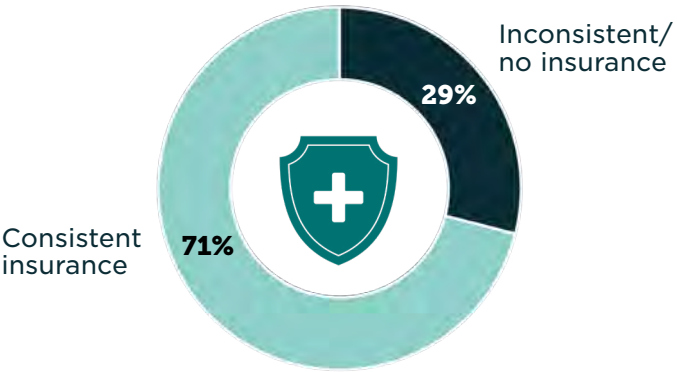
*We do not know whether the opportunity youth in our analysis were disconnected from school and work prior to giving birth.

Opportunity youth have access to, and may need, different types of supports.

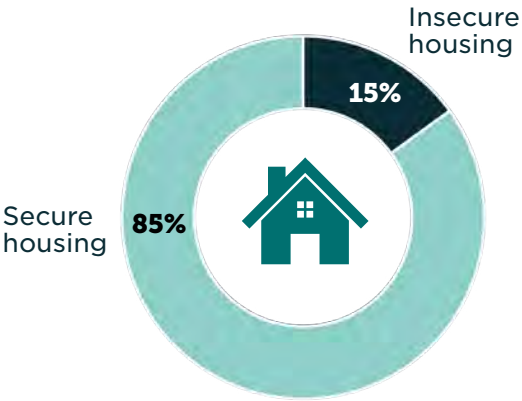
Percent of opportunity youth by household income



Percent of opportunity youth lacking health insurance for at least one month in the past year



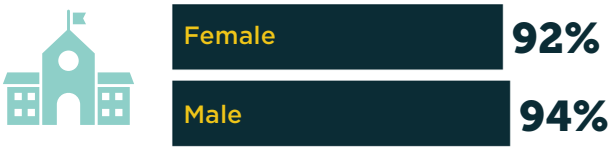
Percent of opportunity youth who had insecure housing in the past year*



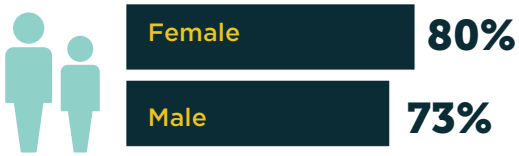
*Lacked a permanent place to stay at least one night in the past year

Most opportunity youth have received information about sexual and reproductive health through both formal education (school or community-based) and informal conversations.*

Received formal sex education in school or a community setting



Have talked to their parents about SRH



*Topics may have included condom use, where to get birth control, HIV/AIDS, and/or STIs. We do not know the timing or quality of the information.

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Understanding the Research on Sexually Transmitted Infections: A Focus on Youth Involved with the Child Welfare or Juvenile Justice Systems or Experiencing Homelessness

Amanda M. Griffin, Colleen Schlecht, & Melissa Kull

Activate aims to bridge the gap between research and practice in support of the Office Population Affair's mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating resources for use by professionals who work in systems with youth involved with the child welfare and juvenile justice systems, youth experiencing homelessness, and youth who are disconnected from school and work. These groups can be referred to collectively as Activate's focal populations.[a]

This fact sheet presents findings from research on sexually transmitted infections (STIs) among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness.[b] It is designed for youth-supporting professionals who want to better understand both the risk for and prevention of STIs among these populations. These professionals can use the information included in this fact sheet to write grant proposals, develop programs, or educate stakeholder groups, among other activities. The studies cited were identified as part of a 2020 review of the literature on pregnancy and STI prevention among Activate's focal populations.

STI Rates Among Youth and Young Adults

Rates of sexually transmitted infections (STIs) among adolescents and young adults in the U.S. have increased over the past decade.[1] Young people ages 15 to 24 years old account for approximately half of new STIs in the U.S. each year despite comprising only a quarter of the sexually active population.[2] However, national data may obscure important differences in STI rates between adolescents and young adults in the broader population and youth involved with the child welfare or juvenile justice systems and youth experiencing homelessness.

To date, relatively few studies have examined STI rates specifically among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness. Moreover, the research that has measured STI rates among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness is limited in two important ways. First, those studies have generally been based on self-reported data collected from young people whose characteristics and experiences may not reflect the characteristics and experiences of the larger population of youth who are involved with the child welfare or justice systems or experiencing homelessness. Second, those studies have generally not included comparison groups of same-aged peers.

a. For more information, please visit www.activatecenter.org.
b. Our review found no studies of STIs among opportunity youth (i.e., youth not working or enrolled in school).

STI Rates Among Youth Involved with the Child Welfare System

Relatively few studies have examined the prevalence of STIs among youth involved with the child welfare system, and the few studies that exist have yielded conflicting results.

One study found that STI rates among youth entering foster care are comparable to national prevalence estimates.[3] However, other studies have found higher STI rates among youth currently or formerly in foster care than among their same-aged peers without a history of child welfare system involvement for some types of STIs.[4,5]

National estimates indicate that STI rates among the general adolescent population vary by sex and race/ethnicity.[2] However, little is known about whether and how STI rates vary by sex or race/ethnicity among youth involved with the child welfare system. Additionally, researchers have not examined whether STI rates among youth involved with the child welfare system vary based on maltreatment or foster care placement histories.[6]

STI Rates Among Youth Involved with the Juvenile Justice System

Several studies, including a few systematic reviews, have examined STI rates among youth involved with the juvenile justice system.[c]

Overall, research indicates that youth in the juvenile justice system have high rates of STIs compared to their peers in the general population.[7–9] These studies also find higher rates of sexual risk-taking behaviors, such as using condoms inconsistently, having sexual intercourse while under the influence of alcohol or other drugs, and having multiple sexual partners.[7,8] Research on STI rates among youth involved with the juvenile justice system also consistently finds higher rates of STIs among young females than among young males.[10–14] For example, these studies suggest that the prevalence of gonorrhea and chlamydia may be two times higher among incarcerated young males and three times higher among incarcerated young females than among their counterparts in the general adolescent population.[7] Some of this research suggests that this difference may be due to a history of childhood sexual abuse or other victimization, which increases sexual risk-taking behaviors during adolescence.[12,14]

STI Rates Among Youth Experiencing Homelessness

National data on the prevalence of STIs among youth experiencing homelessness do not exist. Rather, what we have are estimates from several studies of relatively small samples of youth whose characteristics and experiences do not necessarily reflect the characteristics and experiences of the larger population of youth experiencing homelessness.

Two systematic reviews of the literature on the prevalence of STIs among youth experiencing homelessness have been conducted:

- The first review included nine studies published between 2000 and 2015. Four of these studies were based on youth self-reports of having had an STI. This review found STI rates ranging from as low as 6% to as high as 32%.[15]
- The second review included five studies published between 2000 and 2016. All these studies were based on STI biospecimen testing. This review found STI rates ranging from 0.4%–17% among youth experiencing homelessness.[16]

There are no national STI prevalence estimates for youth experiencing homelessness. However, STI rates reported by studies of youth experiencing homelessness are higher than STI rates among young adults in the general population.[17]

The comparatively higher prevalence of STIs among youth experiencing homelessness has been attributed to their higher rate of engagement in sexual risk-taking behaviors in exchange for food, shelter, and other basic needs.[15] Studies of STI rates among

c. A systematic review involves identifying, appraising, and synthesizing all relevant studies on a particular topic using a comprehensive and predetermined search strategy.

youth experiencing homelessness have generally found higher rates among females (with estimates ranging from 16.7% to 46%) than among males (with estimates ranging from 9% to 13.1%).[15]

More Research on STI Rates Is Needed to Inform Practice

Research on STI rates among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness is extremely limited. It is difficult to apply the findings from individual studies to the larger population of youth who are homeless or involved with systems. More research is needed to understand the prevalence of STIs among youth involved with systems or experiencing homelessness, variation in STI rates among those youth, factors that contribute to that variation, and changes in STI rates among those populations over time.

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Understanding the Research on Condom Use:

A Focus on Youth Involved with the Child Welfare or Juvenile Justice Systems or Experiencing Homelessness

Melissa Kull, Colleen Schlecht, & Amanda M. Griffin

Activate aims to bridge the gap between research and practice in support of the Office Population Affair's mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating resources for use by professionals who work in systems with youth involved with the child welfare and juvenile justice systems, youth experiencing homelessness, and youth who are disconnected from school and work. These groups can be referred to collectively as Activate's focal populations.[a]

This fact sheet presents findings from research on condom use among youth involved with the child welfare or justice systems or youth experiencing homelessness. It is designed for youth-supporting professionals who want to better understand both the risk for and prevention of STIs among these populations. These professionals can use the information included in this fact sheet to write grant proposals, develop programs, or educate stakeholder groups, among other activities. The studies cited were identified as part of a 2020 review of the literature on pregnancy and STI prevention among Activate's focal populations.

Condom Use Among Adolescents in the U.S.

Condoms can be used to protect against both pregnancy and sexually transmitted infections (STIs). In 2019, one national study found that 54% of sexually active high school students reported using a condom the last time they had sexual intercourse.[1] The same study found that sexually active high school students were more likely to report using condoms than to report using any other form of contraception.[b,1] The low rates of condom use among students could reflect a lack of knowledge of, comfort with, or access to condoms. It could also reflect difficulty negotiating condom use or using condoms consistently while under the influence of alcohol or other drugs.

Research on Condom Use Among Youth Involved with the Child Welfare or Juvenile Justice Systems or Youth Experiencing Homelessness

Relatively few studies have examined the rate of condom use among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness, and it is difficult to draw conclusions from those studies.

a. For more information, please visit www.activatecenter.org.
b. Youth who only reported sexual activity with same-sex partners were excluded from the analysis of contraceptive methods.

There are no national studies of condom use among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness. Instead, researchers have focused on better understanding factors related to condom use among those populations. This research is limited in two important ways. First, the studies generally involve young people whose characteristics and experiences may not reflect the characteristics and experiences of the larger population of youth who are homeless or involved with systems. Second, most studies do not compare rates of condom use among youth who are involved with the child welfare or juvenile justice systems or experiencing homelessness to rates of condom use among the broader adolescent population.

Risk and Protective Factors Associated with Condom Use

Much more is known about the risk and protective factors associated with condom use among youth experiencing homelessness than among youth involved with the child welfare or juvenile justice systems.

Two studies have examined risk and protective factors associated with condom use among youth involved with either the child welfare or juvenile justice systems:

- A study of youth on probation found that more frequent marijuana use at baseline was associated with a greater reduction in condom use over the two-year study period. Additionally, youth who reported using marijuana the last time they had sexual intercourse were less likely to have used a condom than youth who did not report using marijuana.[2]
- A study of youth involved with the child welfare system found that recent illegal substance use and symptoms of depression were associated with less condom use.[3]

Multiple studies have examined a range of risk and protective factors associated with condom use among youth experiencing homelessness:

- Youth experiencing homelessness are more likely to use condoms if they have positive attitudes about condoms, have talked with their partner about condom use, have spoken with a teacher or healthcare provider about safer sex, or have condom-using peers.[4,5,6]
- The rate of condom use is lower the longer youth have experienced homelessness. It is also lower among youth who are staying in public places or with strangers than among youth staying in shelters. This difference could reflect the fact that youth staying in shelters are less vulnerable to sexual exploitation and have less need to engage in survival sex.[7,8]

Condom Use and Sex[d]

Research suggests that sex differences in condom use do exist among youth involved with the child welfare or juvenile justice systems and youth experiencing homelessness.

In a recent national study, 60% of sexually active male high school students reported that they had used a condom, but only 50% of sexually active female high school students reported that their male partner had used a condom the last time they had sexual intercourse. Similarly, 49% of sexually active male high school students reported that condoms were their primary method for pregnancy prevention, compared to 39% of sexually active female high school students.[1]

A few studies have examined sex differences in condom use among youth involved with the child welfare or juvenile justice systems:

- One study found that females who had been in foster care at age 17 were more likely to report inconsistent condom use than young males.[9]
- In another study, Black females in foster care were more likely to be concerned about how they would be perceived if they obtained, carried, or used condoms than Black males in foster care. Black females in foster care also felt less empowered to use condoms than Black males in foster care and they reported challenges negotiating condom use with their often older male sexual partners.[10]

c. None of the studies we reviewed specified whether they were asking about external (sometimes referred to as "male") condoms, internal (sometimes referred to as "female") condoms, or both. Nor was it always clear whether the studies were asking about condom use with both different-sex and same-sex partners.

- A third study found that young men on probation were more likely to report intentions to use condoms and frequent condom use than young women. However, young women on probation reported more positive attitudes about using condoms than young men.[11]

Studies of sex-based differences in condom use among youth experiencing homelessness have produced inconsistent findings:

- Some studies have found lower rates of condom use among females than among males.[4,12] However, one study found no sex-based differences in condom use.[13]
- When studies have found sex-based differences in condom use among youth experiencing homelessness, those differences mirror the findings on sex-based differences in condom use among the broader adolescent population.1 That is, young men are more likely to report using condoms than young women. This difference could reflect the challenges young women, particularly those engaging in survival sex, face negotiating condom use.

Condom Use and Sexual Orientation

Little is known about the relationship between condom use and sexual orientation among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness.

The researchers who examined condom use among a national sample of high school students did not report rates of condom use separately for students who reported having same-sex partners, students who reported having different-sex partners, or students who reported having both different-sex and same-sex partners.[1]

- Researchers have generally not examined the relationship between condom use and sexual orientation among youth involved with systems or experiencing homelessness.
- One exception is a study of female youth involved with the juvenile justice system. It found that females who identified as lesbian, bisexual, or questioning were more likely to use condoms than females who identified as heterosexual.[14] However, the sample was small, and the findings have not been replicated by other studies.

Condom Use and Race or Ethnicity

Few studies have examined whether condom use among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness varies by race or ethnicity or why racial or ethnic differences in condom use exist when they have been found.

In a recent national study, 50% of sexually active Latinx high school students, 42% of sexually active white high school students, and 37% of sexually active Black high school students reported using condoms as their primary method for pregnancy prevention.[1] The study also found that 56% of sexually active Latinx high school students, 56% of sexually active white high school students, and 48% of sexually active Black high school students reported using a condom the last time they had sexual intercourse.

Researchers who study condom use among youth involved with the child welfare or juvenile justice systems or youth experiencing homelessness have generally not reported rates of condom use separately for Black youth, Latinx youth, and white youth. When differences in racial or ethnic differences in condom use have been observed, they were incidental findings and not a focus of the research.[3,15-17]

More Research on STI Rates Is Needed to Inform Practice

Research on condom use among youth involved with systems or youth experiencing homelessness is limited. No two studies have focused on the same set of risk and protective factors, making it difficult to know if any of the findings can be applied to the larger population of youth who are experiencing homeless or involved with systems. Additionally, more research is needed to understand why youth involved with systems or youth experiencing homelessness do or do not use condoms.

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A Practical Tool for Building Data Collection and Data Use Capacity in Youth-Supporting Organizations

Amanda M. Griffin, Samuel Beckwith, and Gabriella Guerra

Organizations that support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work routinely face situations in which they need to collect or use data on sexual and reproductive health. These data can be used to inform decisions, improve services, or better understand the populations the organizations serve. Without the capacity to collect and use data, organizations may be unable to best serve young people.

Consider the following two scenarios in which staff at youth-supporting organizations face common data-related issues.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

Moving from Anecdotes to Actionable Data

It's 9:30 a.m. at a congregate care facility. The Executive Director kicks off the weekly staff meeting. She explains that, to better support the young people they serve, the organization needs a clearer understanding of young people's **sexual and reproductive health care service needs and their experiences accessing sexual and reproductive health care**. Staff have various information sources: anecdotes and observations, as well as intake forms and case files. Unfortunately, no one knows what to do with this information or how to interpret it.

Balancing Information Needs and Privacy

It's 4:45 p.m. at a drop-in center, and the youth support team is wrapping up the week with a quick debrief. Several young people requested information about emergency contraception and clinics where they could get STI testing. The team begins wondering whether the needs of young people may be changing, but it is hard to know whether this reflects a real shift or just an unusual week. They quickly realize that they need to **know more about the sexual and reproductive health behaviors of the young people they serve**. After one staff member suggests collecting this information during intake, another expresses concern about collecting such sensitive information.

In these scenarios, youth-supporting professionals recognized a gap in organizational knowledge about young people's sexual and reproductive health or their sexual and reproductive health care service needs. Their organizations either did not collect sexual and reproductive health-related data or did not know how to use the data they collected.

This five-module tool describes ways youth-supporting professionals and their organizations could increase their capacity to collect and use data on sexual and reproductive health to address the types of challenges shared in these scenarios. It can help youth-supporting professionals understand *why* they should collect sexual and reproductive health data from the youth they serve and decide *what* data to collect. It can also help them interpret those data and report the information responsibly.

How does this tool build upon existing Activate resources?

This tool builds upon Activate's previous summaries of the sexual and reproductive health data of youth experiencing homelessness, youth experiencing the child welfare system, youth experiencing the justice system, and youth disconnected from school and work (i.e., opportunity youth). It provides guidance on how youth-supporting professionals and their organizations can collect their own data about young people's sexual and reproductive health and use those data responsibly.

Who is this tool for?

This tool is designed to be accessible to all youth-supporting professionals. This includes direct service providers and program managers, as well as youth-supporting organizations, such as organizations that provide services to young people in foster care or young people experiencing homelessness. This tool can be helpful regardless of youth-supporting professionals' current capacity to collect and use data.

The tool is divided into five stand-alone modules that offer practical guidance. Each module can be accessed and downloaded separately.

Table 1. Module List and Description

Module Title		Description
	Module 1: Key Considerations for Collecting Sexual and Reproductive Health Data	Explains why, how, and by whom sexual and reproductive health data may be collected
	Module 2: Choosing Which Sexual and Reproductive Health Questions to Ask	Identifies sources of sexual and reproductive health questions
	Module 3: Protecting Privacy and Confidentiality	Discusses the protection of young people's privacy and data confidentiality
	Module 4: Making Sense of Data Using Local, State, and National Comparisons	Explains *why* making comparisons can be helpful and *where to find* comparison data
	Module 5: Reporting Data Responsibly	Discusses the importance of presenting data in ways that provide context, avoid stigmatizing young people, and promote understanding

Module 1: Key Considerations for Collecting Sexual and Reproductive Health Data

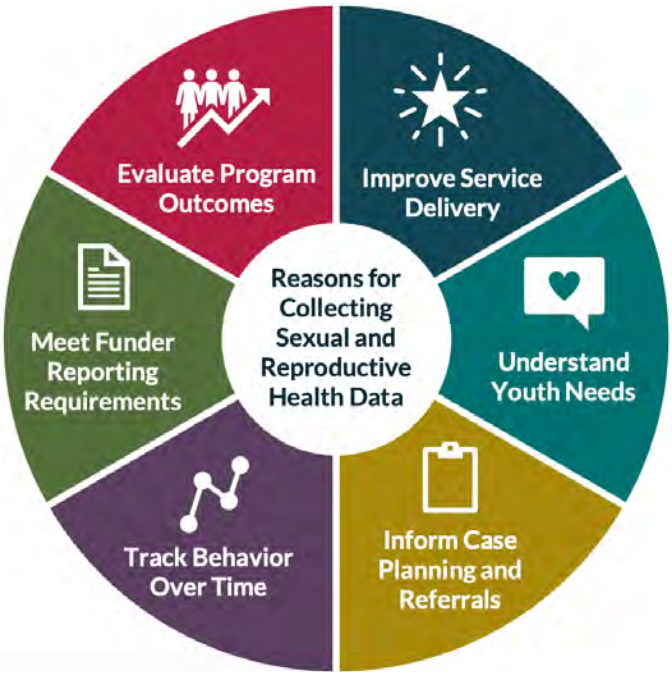
Before deciding what sexual and reproductive health data to collect, youth-supporting organizations might ask themselves the following questions:

KEY CONSIDERATIONS

- Why are they collecting the data?
- How will the data be collected?
- Who can support data collection?
- What will the timing of data collection be?
- Will staff need training to collect the data?
- How often will data be collected?

Why collect sexual and reproductive health data?

Collecting sexual and reproductive health data without a clear purpose can create an unnecessary burden for both youth-supporting professionals and the young people they work with. Hence, it is important for youth-supporting professionals to know that they are collecting sexual and reproductive health data for a reason and not just for the sake of data collection.



Youth-supporting organizations may collect data to improve service delivery, understand young people's needs, inform case planning or referrals, track change over time, meet funder requirements, or evaluate outcomes. Table 1.1 lists common reasons for collecting data about sexual and reproductive health with example scenarios and data-driven solutions.

Table 1.1. Reasons for Collecting Sexual and Reproductive Health Data, Example Scenarios, and Data-Driven Solutions

Reasons	Scenario	Data-Driven Solution
Improve Service Delivery	Staff collect data from young people about their access to contraception and find that they do not have transportation to access the local clinic that provides contraception.	Establish a bi-monthly free ride program from the organization's office to the local clinic.
Understand Youth Needs	Staff survey young people to learn what they know about sexually transmitted infections (STIs) and find a significant knowledge gap.	Offer a workshop on STI prevention and treatment.
Inform Case Planning and Referrals	Staff routinely ask young people if they know where they can access sexual and reproductive health care services. Many young people report that they do not know where to go to obtain care.	Use Activate's *Identifying Accessible Sexual and Reproductive Health Resources in Your Community* to help identify and connect young people to local clinics.
Track Behavior Over Time	Staff observe an increase in the prevalence of risky sexual behaviors such as failure to use condoms based on data collected at intake and every six months thereafter.	Implement a new sexual health education curriculum.
Meet Funder Reporting Requirements	A youth-supporting organization is required to report the number of young people who participated in a sexual health education program to the funder.	Staff use a spreadsheet to track attendance in compliance with the funder's reporting requirements.
Evaluate Program Outcomes	Staff implement a sexual health curriculum and want to know if the sexual behaviors of the young people who participate in the training are changing.	Staff use a survey to ask young people about their sexual behaviors before and after the training.

Who can support data collection?

Responsibility for collecting sexual and reproductive health data does not need to fall on one staff member or team. Direct service providers, program administrators, data managers, and research partners may all play a role.

Will staff need training to collect the data?

Collecting data on sexual and reproductive health inevitably involves asking questions about sensitive topics. Consequently, youth-supporting organizations should ensure that the staff who are responsible for collecting those data are adequately trained to collect the data in a nonjudgemental, trauma-informed way that protects privacy and confidentiality (see **Module 3**). Organizations may choose to provide training themselves or bring in outside experts who have experience collecting this type of sensitive data.

How will the data be collected?

One option for collecting data is to ask young people to fill out an intake form, screening tool, or self-administered survey. Another option is for staff to ask young people questions and record the responses. Although some young people may feel more comfortable with the former, young people with limited literacy skills may prefer the latter. Building data collection into existing workflows can help make data collection more manageable and sustainable.

What will the timing of data collection be?

Timing is important when asking questions about sensitive topics such as pregnancy, STIs, or sexual health behaviors. In some cases, it may make sense to build rapport with young people before asking these questions. In other cases, such as when young people may need referrals or immediate support, asking these questions during intake may be more appropriate.

How often will data be collected?

Data should only be collected as frequently as needed to minimize the burden that collecting data places on both young people and youth-supporting professionals. Some information may only need to be collected once; other information may need to be collected repeatedly to understand change over time (e.g., increased access to contraception).

Module Takeaways

- Collect sexual and reproductive health data with a clear purpose, such as informing decisions or tracking change over time.
- Have a plan for how the data will be used to improve services, understand the needs of young people, or inform decision making.
- Integrate data collection into existing workflows to increase sustainability.
- Be intentional about the timing and frequency of data collection, especially when the data involve sensitive topics.

Reflection Questions

- What sexual and reproductive health related information could your organization collect from youth?
- How will collecting data on sexual and reproductive health benefit the young people your organization serves?
- Who in your organization could be involved in data collection, and in what ways?
- How will your organization make decisions about the timing of data collection?

Module 2: Choosing Which Sexual and Reproductive Health Questions to Ask

Once youth-supporting organizations know why they are collecting data on sexual and reproductive health, their next step is to decide which questions they will ask. Sexual and reproductive health encompasses a wide range of topics, including receipt of sex education or sexual health services, sexual activity, condom and contraceptive use, sexual and reproductive health knowledge, sexual and reproductive health care access, and sexual and intimate partner violence.

Youth-supporting organizations do not need to collect data on every topic; rather, they should ask questions that will provide them with the data they need to support the young people they serve. Additionally, organizations should ask clear, age- and developmentally appropriate questions that youth will feel comfortable answering. It is also important to give young people the option to skip any questions they do not wish to answer.

Whenever possible, youth-supporting organizations should select questions that have already been developed and tested (or *validated*) with youth to ensure that they are clear, concise, and produce accurate responses. Another benefit of choosing validated questions is that they may allow youth-supporting organizations to compare the data they collect to data collected as part of studies involving similar populations.

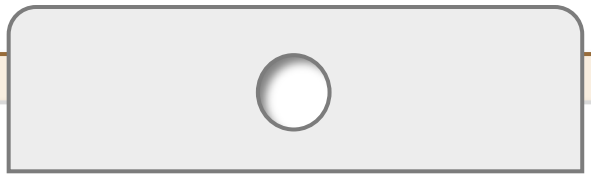
Building Foundational Knowledge

The following concepts are used in this section and may be helpful to understand. These are terms commonly used in research and evaluation.

- **Measure:** A question, item, or tool used to gather information about the quantity or characteristics of what is being studied.[1]
- **Validated:** A measure or tool that has been tested and shown to accurately assess what it was intended to measure.[2]
- **Youth-centered:** An approach that prioritizes the active participation, perspectives, needs, and strengths of youth.[3,4,5]
- **Response burden:** The amount of time, effort, or stress experiences when completing a questionnaire or participating in a study.[6]

The figure below includes a curated list of questions related to the sexual and reproductive health topics that were featured in Activate's sexual and reproductive health data summaries for youth experiencing homelessness, youth experiencing the child welfare system, youth experiencing the justice system, and youth disconnected from school and work.

Figure 2.1. Sexual and Reproductive Health-Related Questions[7-11]



Sex Education[7]

Which, if any, of these topics have you ever talked with a parent or guardian about?

- ❑ How to say no to sex
- ❑ Methods of birth control
- ❑ Where to get birth control
- ❑ Sexually transmitted diseases
- ❑ How to prevent HIV/AIDS
- ❑ How to use a condom
- ❑ Waiting until marriage to have sex
- ❑ None of the above

Have you ever had any formal instruction at school, church, a community center, or some other place about [INSERT ANY OF THE ABOVE TOPICS]?

- ❑ Yes
- ❑ No

Receipt of Sexual Health Services[8]

In the past year, have you received family planning counseling or services?

- ❑ Yes
- ❑ No

Where did you receive family planning counseling or services? (Check all that apply)

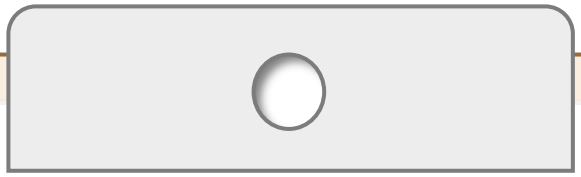
- ❑ Private doctor's office
- ❑ Community health clinic
- ❑ School
- ❑ Hospital
- ❑ Some other place

Sexual Activity[9]

Have you ever had sexual intercourse?

- ❑ Yes
- ❑ No

Figure 2.1. Sexual and Reproductive Health-Related Questions (cont.)



Sexual Activity (cont.)[9]

During the past 3 months, with how many people did you have sexual intercourse?

- ❑ I have never had sexual intercourse
- ❑ I have had sexual intercourse, but not during the past 3 months
- ❑ 1 person
- ❑ 2 people
- ❑ 3 people
- ❑ 4 people
- ❑ 5 people
- ❑ 6 or more people

Did you drink alcohol or use drugs before you had sexual intercourse the **last time**?

- ❑ I have never had sexual intercourse
- ❑ Yes
- ❑ No

Condom and Contraception Use[9]

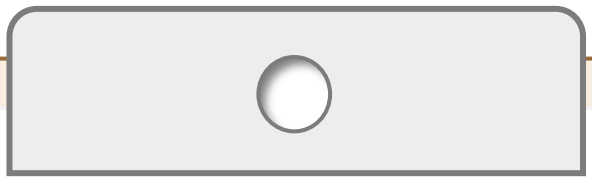
The **last time** you had sexual intercourse, did you or your partner use a condom?

- ❑ I have never had sexual intercourse
- ❑ Yes
- ❑ No

The **last time** you had sexual intercourse with an opposite-sex partner, what one method did you or your partner use to prevent pregnancy?

- ❑ I have never had sexual intercourse with an opposite-sex partner
- ❑ No method was used to prevent pregnancy
- ❑ Birth control pills (Do not count emergency contraception such as Plan B or the "morning after" pill.)
- ❑ Condoms
- ❑ An IUD (such as Mirena or ParaGard) or implant (such as Implanon or Nexplanon)
- ❑ A shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing)
- ❑ Withdrawal or some other method
- ❑ Not sure

Figure 2.1. Sexual and Reproductive Health-Related Questions (cont.)



Sexual and Reproductive Health Care Access[9]

Have you ever been tested for HIV? (Do **not** count tests done if you donated blood.)

- ❑ Yes
- ❑ No
- ❑ Not sure

During the past 12 months, have you ever been tested for a sexually transmitted infection (STI), such as chlamydia or gonorrhea?

- ❑ Yes
- ❑ No
- ❑ Not sure

Sexual & Intimate Partner Violence[9]

During the past 12 months, how many times did someone you were dating or going out with force you to do sexual things that you did not want to do? Count such things as kissing, touching, or being physically forced to have sexual intercourse.

- ❑ I did not date or go out with anyone during the past 12 months
- ❑ 0 times
- ❑ 1 time
- ❑ 2 or 3 times
- ❑ 4 or 5 times
- ❑ 6 or more times

During the past 12 months, how many times did someone you were dating or going out with physically hurt you on purpose? Count such things as being hit, slammed into something, or injured with an object or weapon.

- ❑ I did not date or go out with anyone during the past 12 months
- ❑ 0 times
- ❑ 1 time
- ❑ 2 or 3 times
- ❑ 4 or 5 times
- ❑ 6 or more times

Pregnancy (Open-ended numeric responses) [10, 11]

[IF FEMALE] How many times have you been pregnant in your life? _____

[IF MALE] To the best of your knowledge, how many times have you made someone pregnant? _____

The questions in Figure 2.1 come from the Youth Risk Behavior Survey (YRBS),[12] the National Survey of Family Growth,[13] and the National Longitudinal Study of Adolescent to Adult Health (Add Health).[14] Table 2.1 provides information about these and other national datasets. Although all four datasets summarized in Table 2.1 include questions about sexual and reproductive health, each has its own focus.

Table 2.1. National Datasets that Include Sexual and Reproductive Health-Related Items

National Datasets	Focus Areas
National Longitudinal Study of Adolescent to Adult Health (Add Health)	Adolescent and adult health, including relationships, sexual behavior, health outcomes, and social and environmental contexts
National Longitudinal Survey of Youth-1997	Transitions from adolescence to adulthood, including education, employment, fertility, family formation, and sexual behaviors
National Survey of Family Growth	Family life, marriage, fertility, contraception use, and sexual health across adolescents and adults
Youth Risk Behavior Survey (YRBS)[15]	Health behaviors among high school–aged youth, including sexual and reproductive health, HIV/STI prevention, and related risk and protective factors

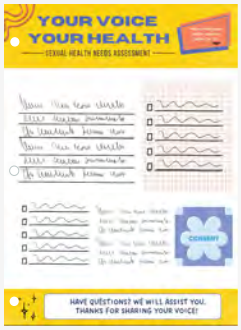
Module Takeaways

- Youth-supporting organizations should draw on existing survey instruments for widely used questions about sexual and reproductive health.
- Youth-supporting organizations should be thoughtful about the questions they ask young people and should avoid asking questions that are not relevant to their data collection goals.

Reflection Questions

- Which sexual and reproductive health topics are most relevant to your organization's goals?
- What data does your organization need to improve service delivery or support decision making?
- How might young people experience or interpret the questions your organization chooses, and are those questions appropriate given the setting and the relationships staff have with young people?

Module 3: Protecting Privacy and Confidentiality



Protecting Sensitive Information

Mina is a case manager at a school reengagement program. Over the past two weeks, Mina has been hard at work developing a sexual health needs assessment for the young people the program serves. When young people are asked to complete the assessment, they voiced some concerns. One young person approaches Mina and says, "This is really personal information. I don't mind sharing it with you, but what's going to happen with it afterward? Are other people going to see my answers to these questions?" Mina isn't sure what to say. The staff had agreed to keep the sexual health data safe but were still figuring out how exactly to do that.

Youth-supporting organizations that collect sexual and reproductive health data have an obligation to protect the privacy of the young people whose data they collect and the confidentiality of those data.

Privacy is the ability to control access to one's personal information.[17] Young people should be able to decide whether they want to share information about their sexual and reproductive health and what information they want to share. Protecting privacy involves, but is not limited to:

- Explaining the data collection process.
- Avoiding unnecessary data collection.
- Collecting data in a private setting.

Confidentiality is the duty to protect data that have been shared from unauthorized disclosure or breach.[18] Maintaining confidentiality involves, but is not limited to:

- Physically or digitally protecting data (e.g., storing data in locked filing cabinets; password protecting data files).
- Limiting data access to those who need it.
- Removing identifying information (e.g., names, addresses) from data files.
- Reviewing any documents before they are published to ensure that individuals cannot be identified.

See the following resources for more information about safeguarding data:

- 10 Ways to Safeguard Data in the Nonprofit Sector (Arizona State University)
- Cybersecurity Assessment Tool (Ford Foundation)

Having an *informed consent* process may be required in some circumstances, such as in the context of a research study or before undergoing a medical procedure.[a] While informed consent requirements may not apply to many youth-supporting organizations, it is still best practice to give youth the opportunity to opt out of data collection activities. This can be done by establishing transparent processes for collecting, protecting, using, and sharing data and discussing the processes with young people before data collection. These processes may be described in a written document that is reviewed with youth prior to data collection. This document, which may be referred to as a *Client Confidentiality Statement* or *Client Privacy Notice*, should be written at an appropriate reading level using language youth will understand rather than jargon or technical terms.

Youth should also have the opportunity to ask any questions they might have about the protection and use of their data. Having transparent processes can help youth-supporting professionals build trust with youth and empower youth to make informed decisions about whether they want to share information related to their sexual and reproductive health.[16]

Module Takeaways

- Protecting privacy and confidentiality is a core responsibility for youth-supporting organizations that collect sexual and reproductive health-related data.
- Explaining to young people how their data will be collected, protected, shared, and used allows them to make informed decisions and builds trust with them.

Reflection Questions

- How does your organization protect young people's privacy during data collection, and how is the confidentiality of the data your organization collects maintained?
- How could those privacy and confidentiality protections be improved?
- What do young people need to know about how your organization protects, shares, and uses data?

[a] Informed consent is the process by which a person voluntarily agrees to participate in a study, receive a medical procedure, or share personal information after being given clear, complete, and understandable information about what that participation involves.

Module 4: Making Sense of Data Using Local, State, and National Comparisons

This module describes how youth-supporting organizations can use comparison data to help make sense of the data they collect.

One approach is to compare what their data tell them about the sexual and reproductive health of the youth they serve **to what is known from studies involving similar populations.** Activate's infographics on the sexual and reproductive health of youth experiencing homelessness, the justice system, the child welfare system, or disconnection from school and work can facilitate these comparisons.

Another approach is to compare what their data tell them about the sexual and reproductive health of the youth they serve **to local, state, or national benchmarks.** Making these comparisons can help youth-supporting organizations:

- Understand how the young people they serve are faring relative to their peers or other similar populations.
- Set realistic and meaningful goals for improving the sexual and reproductive health of the young people they serve.
- Demonstrate need to funders and other partners.

Whether youth-supporting organizations should compare their data to local, state, or national benchmarks depends on what they want to learn.

Sources of local data

Comparisons involving local data are a good option for youth-supporting organizations that want to know how the young people they serve are faring relative to other young people who live in the same geographic area. Local data sources may include the following:

- **County or city health/public health departments** may publish data on STI rates, teen births, or other sexual and reproductive health statistics.
- **Community health needs assessments** may include sexual and reproductive health indicators.
- **Hospital and health care systems** may publish community health reports that include statistics related to sexual and reproductive health.
- **School districts** that administer the Youth Risk Behavior Survey (YRBS) may publish their results, which can also be found here.

Hypothetical Example: Using Local Data

Only 5% of the young people being served by a youth-supporting organization reported being screened for an STI in the past year. A community health assessment found that a similarly low proportion of youth across the city had been screened. The organization connects with the local public health department to discuss options for integrating screening within programs across the city that serve youth.

State data sources

Comparisons involving state-level data are a good option for youth-supporting organizations that want to know how the young people they serve are faring relative to other young people in their state. State data sources may include the following:

- **State health/public health departments** may publish data dashboards or reports on STI rates, teen pregnancy, birth outcomes, and sexual or reproductive health care service use.
- **State Title X Family Planning grantees** may publish reports that include service use and outcome data.
- States may publish their **Youth Risk Behavior Survey** results, which can also be found here.

Hypothetical Example: Using State Data

30% of the youth being served by a youth-supporting organization reported using a condom the last time they had sex. A staff person finds the "used a condom during last sexual intercourse" item on the YRBS webpage and then selects their state. According to the most recent data, 60% of the state's high school students used a condom the last time they had sex. The organization decides to implement a program that has been shown to increase condom use.

National data sources

Comparisons involving national data are a good option for youth-supporting organizations that want to know how the young people they serve are faring relative to young people across the country. The national data may be based on the entire youth population or a nationally representative sample.

- **Centers for Disease Control and Prevention (CDC)** publishes national and state data on STIs, teen births, contraceptive use, and adolescent health behaviors, data on family life, fertility, and reproductive health from the **National Survey of Family Growth**, and national, state, and school district-level YRBS data.
- **Office of Population Affairs (OPA)** publishes reports with national estimated related to family planning and Title X programs.
- **National Center for Health Statistics** publishes national data on births, fertility rates, and maternal and reproductive health outcomes.

Hypothetical Example: Using National Data

A youth-supporting organization surveyed the female youth it serves and found that 70% of contraceptive users were using a hormonal or long-acting contraceptive method. Curious how this compares to national data, a staff person goes to OPA's Title X Family Planning Annual Report summary and finds that 60% of female Title X clinic clients used a hormonal or long-acting contraceptive method.

Module Takeaways

- Youth-supporting organizations can make sense of their data by comparing what their data say about the sexual and reproductive health of youth they serve to local, state, or national benchmarks.
- Youth-supporting organizations can draw upon local, state, and national sources to make those comparisons.

Reflection Questions

- How can making comparisons to other data help your organization meet its goals?
- Which Activate infographic on the sexual and reproductive health of young people would best help your organization?
- Which type of comparison (that is, local, state, or national) are most relevant to your organization's goals?
- What contextual factors, such as differences in resources, geography, or population, should your organization consider when interpreting comparison data?
- How can you ensure that comparisons are used to support rather than unintentionally stigmatize youth?

Module 5: Reporting Data Responsibly

Comparing the sexual and reproductive health-related data youth-supporting organizations collect to sexual and reproductive health-related data from local, state, or national sources (see **Module 4**) can help youth-supporting organizations understand their data. It is important for youth-supporting organizations to report sexual and reproductive health data responsibly. These comparisons can lead to incomplete pictures, misleading interpretations, or oversimplified conclusions if they are presented without sufficient context. Context includes a range of social, geographic, and historical details that can shape young people's experiences (e.g., mistrust of health providers), affect their access to sexual and reproductive health care services (e.g., lack of services in rural areas), and contribute to gaps in sexual and reproductive health.[17]

Data can be framed and explained in ways that reinforce stigma or support a strengths-based understanding of young people's sexual and reproductive health.

Below are some tips related to *language, framing, and interpretation* that can help youth-supporting organizations report sexual and reproductive health data responsibly.

Use person-centered language.

Place the person rather than their condition first and foremost. For example, use *young people in foster care* instead of *foster youth.*

Be specific about whom you are referring to.

Avoid vague language when referring to groups. That makes it difficult to determine who is included and who is not — for example, "at-risk youth."

Do not center one type of person as the norm.

Avoid positioning one group as the default or "norm" and other groups as "different" or "non-normative" when making comparisons.

Take a strengths-based approach.

Do not minimize the challenges young people face but also highlight their accomplishments, resilience, and areas in which they are thriving.

Pair statistics with personal narratives.

When appropriate, humanize the data by pairing them with quotes or stories (keeping in mind **Module 3's** discussion of privacy and confidentiality) to help audiences understand young people's experiences.

Empower youth.

Whenever possible, involve young people in shaping how data about their sexual and reproductive health are framed and communicated.

Visualizing data can shape how people interpret and respond to data. Choices about what data are shown and how they are presented can influence what audiences take away from data visualizations. Thoughtful visual design can help audiences focus on the most important takeaways without misinterpretation.

Below are some tips for visualizing data.[18]

- **Be intentional about what you present.** Consider your intended audience, the questions they need answered, and how they will use the information.
- **Make the data clear and accessible.** Use descriptive titles, plain labels, short definitions, and explanatory notes where needed. Apply accessibility best practices, including readable color contrast and simple formatting.
- **Keep it simple.** Limit each visual to one key message, split up complex information across multiple visuals, and order them to tell a coherent story.
- **Use visuals to reinforce meaning.** Choose chart types and layouts that make patterns clear and data easy to interpret.

Table 5.1 includes a list of resources where youth-supporting professionals and their organizations can find practical guidance on data visualization and communication.

Table 5.1. Additional Resources on Data Visualization and Communication

Source	Description
Data Viz Project	Comprehensive, interactive library that can be used to explore different ways to visualize data (for example, charts, maps, diagrams) and select the right format based on the data type and communication goal
Census Data Visualization Gallery	Curated gallery of data visualizations created using U.S. Census data that demonstrate how complex datasets can be translated into clear, engaging visuals for broad audiences
The Sharing Survey Results Tip Sheet	Practical guidance on communicating survey findings effectively by tailoring messages, using clear visuals and plain language, and focusing on key takeaways
Communicating with Census Data: Data Visualization	Practical guidance on best practices for designing effective visuals, including how to choose formats (for example, tables, charts, maps) and improve clarity to make data accessible and help communicate key insights

Module Takeaways

- Data without context may be misunderstood or even stigmatize the young people you serve.
- Consider your framing and the language you use to discuss and interpret your data.
- Simple, accessible, and appealing data visualizations are a powerful tool for getting your message across.

Reflection Questions

- Think about a time when you encountered data about a group of young people. How were those data framed, and what impact did that framing have on your perception?
- What are some ways you can ensure that the data you share do not unintentionally reinforce stigma?
- What does a strengths-based narrative look like in practice when sharing data about young people?

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About the Authors

Amanda M. Griffin, PhD, is a researcher at Chapin Hall.

Sam Beckwith, PhD, is a research scientist at Child Trends.

Gabriella Guerra, BA, is a senior research analyst at Child Trends.

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Module 2: Healthy Relationships

What's Inside? Resources provide practical guidance and conversation tools to help youth-supporting professionals discuss healthy relationships, consent, boundaries, communication, peer influence, and shared power with young people.

Contents

Relationship characteristics

- Healthy communication
- Boundaries and limits
- Relationship norms
- Positive peer influences
- Power dynamics

Consent guidance

- Seeking, giving, and receiving consent
- Verbal and nonverbal cues
- Situational influences on consent
- Sexual decision-making

Support strategies for professionals

- Trauma-informed approaches
- Digital and interpersonal safety
- Creating supportive spaces
- Youth-centered communication

Practical tools

- Conversation starters and tips
- Reflection and follow-up prompts
- Skill-building activities
- Tips for being a supportive adult
- Ready-to-use training

Module 2 Navigation Matrix

Healthy Relationships

This matrix provides an at-a-glance overview of the resources in Module 2. Use it to quickly identify each type of resource, overlap with other module topics, and the population(s) of young people emphasized. Click a resource title below to jump directly to that resource!

Resource Title	Topic Overlap:			Young People Experiencing...
Healthy Romantic Relationships and Youth Well-being	⚠	🤰		✓ Child Welfare System ✓ Justice System ✓ Homelessness ✓ Disconnection
Crucial Conversations about Healthy Romantic Relationships: A Toolkit for Youth-Supporting Professionals	⚠	🤰	🏥	
Seeking, Giving, and Receiving Consent for Sexual Activity	⚠		🏥	
A Practice Guide for Understanding Consent	⚠		🏥	
Sexual Cyberbullying Research Summary	⚠		🏥	
How to Decode Signs of Sexual Cyberbullying and Support Teens and Youth	⚠		🏥	
Supportive Adult Connections, Teen Pregnancy, and Youth Mental Health		🤰	🏥	
A Practice Guide for Promoting Youth Mental Health and Sexual and Reproductive Health as a Supportive Adult		🤰	🏥	
Harnessing Positive Peer Influence to Reduce Substance Use and Unintended Teen Pregnancy	⚠	🤰		
A Technical Assistance Tool for Helping Youth Navigate Peer Influence	⚠	🤰		
Conversation Strategies for Talking with Young People about Healthy Relationships	⚠			

Resource Types: Research Summary | Practice Guide | Training

Topics: Healthy Relationships | Violence Prevention & Intervention | Pregnancy & Parenting | Sexual & Reproductive Health Care

Healthy Romantic Relationships and Youth Well-being

Rachel Rosenberg, Karlee Naylon, Katelyn Rust, Samuel Beckwith, and Nia-Simone Woods

Purpose

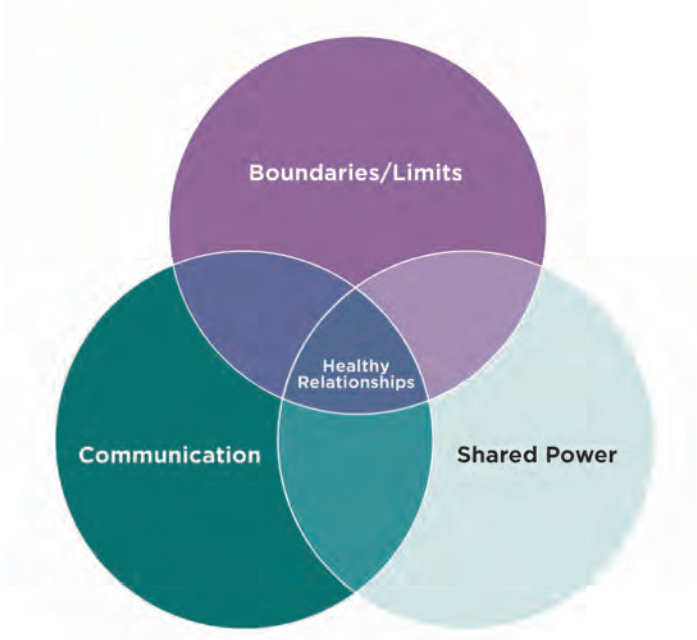
A wealth of research literature describes healthy romantic relationships among adults and youth, broadly, but there is more limited research about healthy romantic relationships among young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth). Most of the available research focuses on youth in foster care and building healthy relationships with their families of origin, foster parents, or peers. Similarly, several practice resources, such as program curricula, describe the importance of healthy romantic relationships among youth. Few of these practice resources include cultural considerations, tools, and actionable techniques for helping young people at greater risk for negative relationship experiences communicate effectively, build and set boundaries, and establish shared power within romantic relationships. Gaps in the research literature—and, therefore, in research-based practice resources—about healthy romantic relationships among youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work limit youth-supporting professionals' capacity to address risk for entering or being in unhealthy relationships among youths with these experiences.

This resource summarizes research and practice literature, provides practice guidance, and describes cultural considerations (e.g., religion, immigration status, and ethnic backgrounds) associated with three key domains of healthy romantic relationships:

- Communication
- Boundaries/limits
- Shared power

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals *bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).*

Figure 1. Components of healthy relationships



ACTIVATE

Overview

Most research about romantic relationships involving young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work focuses on preventing and recognizing the signs of unhealthy romantic relationships. Youth with these experiences are at higher risk for being in unhealthy romantic relationships and experiencing physical or sexual abuse—relative to young people without these experiences—due to certain risk factors, such as:

- A lack of experience observing and experiencing healthy relationships[1-3]
- Risk of instability generally (e.g., housing, school), which may create instability in relationships[4]
- Experiences with trauma associated with systems-involvement, homelessness, or disconnection[5-7]

Youth-supporting professionals should know how to help young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work form, recognize, and understand *healthy* romantic relationships and be able to help them leave an unhealthy romantic relationship. Engaging in romantic relationships is developmentally appropriate during young adulthood: 35 percent of adolescents ages 13 to 17[8] (and almost all youth by age 18) report having dated at some point.[9] Helping young people have healthy relationships may have lasting impacts. Healthy romantic relationships during adolescence and emerging adulthood are shown to be associated with more positive well-being outcomes (e.g., fewer mental health concerns, higher life satisfaction, higher self-esteem).[10] These well-being outcomes are associated with other positive young adult outcomes such as academic success.[11,12]

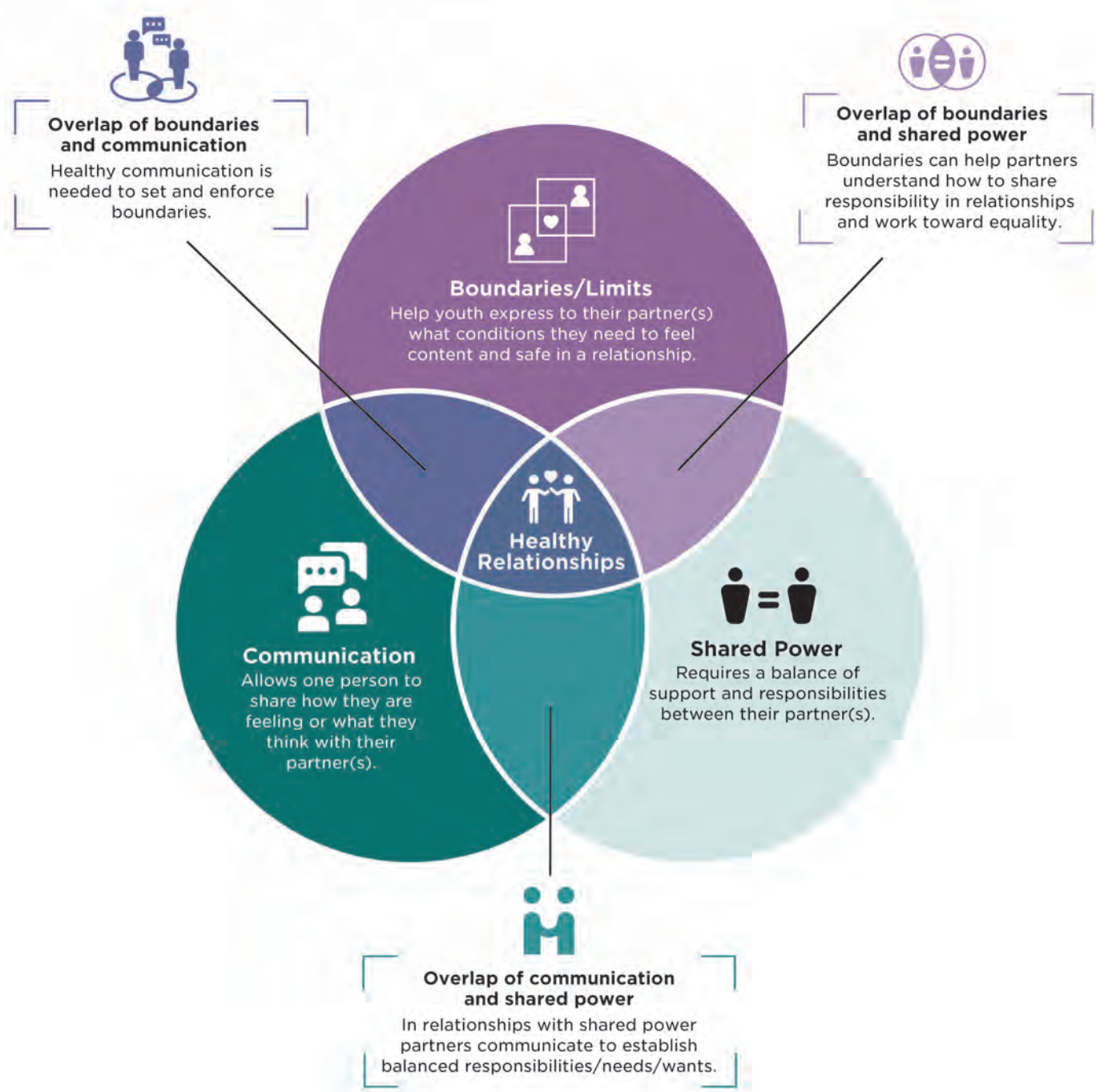
A review of research and practice literature confirms that a broad array of domains are important indicators of healthy romantic relationships.[a] Therefore, we gathered input from a group of advisors (comprised of youth, youth-supporting professionals, program administrators, and researchers) to identify a select set of domains critical for young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. Critical domains we identified include:

- **Communication**, which involves active listening, honesty, and nonverbal communication. Communication allows one person to share how they are feeling or what they think with another.[13]
- **Boundaries/limits**, which helps youth express to their partner(s) what conditions they need to feel content and safe in a relationship.[14]
- **Shared power**, which requires a balance of support and responsibilities.[15] Elements of equity within relationships include an agreed-upon provision of power and support, a sense of fairness, and mutual respect.[16]

These domains overlap and are all needed to foster healthy relationships.[17] For example, equality and mutual respect are needed for a person to feel comfortable communicating their boundaries and enforcing those limits.

[a] Based on the results of the literature review, communication, boundaries/limits, and shared power were often cited as critical to healthy relationships and encompassing of other relationship domains (e.g., healthy communication requires honesty and openness). Activate advisors ranked these three domains as the most discussed with youth and in need of additional resources. For more information, see the methodology section at the end of the document.

Figure 2. Components of healthy relationships



Systemic and cultural considerations also impact how a relationship is structured and, as a result, there may be variation in the ways these domains are observed and experienced. For example, a systemic consideration may include how gender norms in society influence youths' view of roles within a relationship, or norms that are specific to a geographic location. Cultural considerations may include religion, immigration status, and ethnic backgrounds, among other factors.[18,19] Cultural considerations can influence perceptions of relationships and influence expectations and approaches toward understanding their relationships among young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. Cultural considerations that influence healthy romantic relationships may also influence how professionals support youth who have these experiences. Within the discussion of each domain (communication, boundaries/limits, and shared power), we describe research and research-based examples of related systemic and cultural considerations.

Findings

For each healthy romantic relationship domain listed below, we provide a summary of the research and research-based resources on the topic, cultural considerations related to the topic, and a list of research-informed practice tips for supporting youth.

Communication

Youth consistently report that healthy communication is a core relationship value. Communication allows one person to explain what they are experiencing—or what they need—to their partner(s).[20] Research finds that healthy communication between romantic partners has a significant impact on individual well-being and relationship quality and satisfaction for young adults.[21-23] For young parents, communication between co-parents also affects their children's well-being, academic achievement, social skills, and stress levels.[24] Studies also suggest that youth often struggle to communicate with romantic partners and may lack confidence in their own communication skills.[25] These challenges may be magnified for young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work due to their decreased access to and consistent connections with trusted adults or peers who can help them problem solve and limited opportunities to safely practice open and honest communication.[26-28] However, most of the healthy relationship research and practice resources on healthy communication with partners do not address the unique needs of youth with these experiences.

Findings Note

The information about communication discussed here is important, regardless of whether the communication occurs in-person or electronically. Electronic communication through text messages, social media, email, and dating apps has broadened the considerations that youth-supporting professionals may need to make when working with youth on healthy communication skills. For example, 53 percent of young adults ages 18-29, and 8 percent of teens ages 13-17 reported online dating. Among all youth ages 13-17, 57 percent started a friendship in a digital space.[a] While online communication can expand a young person's network, it also introduces additional risk. Estimates of cyberbullying among adolescents ages 12-18 range from 10 percent to 70 percent. There is a gap in research on the prevalence of cyberbullying specifically about dating and within relationships.

[a] Pew Research Center (2023). The who, where, and why of online dating in the US.

Healthy communication can allow partners to handle stressful situations, manage conflict, apologize when needed, help ensure everyone in the relationship is on the same page, and establish a strong sense of understanding and connection.[29] Components of healthy communication include active listening, honesty, and being aware of non-verbal communication.

Healthy communication requires youth to be able to express themselves, regulate their emotions, and have a sense of self-awareness.[30,31] Communication is a precursor for other components of healthy relationships such as setting and enforcing boundaries and addressing power dynamics, which are discussed in the next section.[32-34]

Systemic and cultural considerations to help youth build communication skills

Communication styles and preferences may differ among cultures and therefore influence intercultural relationships. For example, young people may vary in the ways they communicate depending on the cultures they experience and those cultures' use of high and low-context communication. High-context communication relies on heavy use of implicit information like body language, eye contact, and tone of voice. Low-context communication norms include using explicit information like words and facts.[35,36] These differences might lead to miscommunication in partners if one partner uses nonverbal cues and another partner is unaware of those cues.[37] Additionally, different communication styles may not be appropriate for every relationship. For example, a more assertive communication approach, especially for women, may not align with the values and communication patterns within some cultures.[38] Young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work may need to adapt their communication style to maintain safety in a relationship.[39] For example, an assertive communication approach may not be effective if it increases the likelihood of a negative or violent response from a partner. Youth-supporting professionals should be aware of differences in communication that are shaped by a particular partner, and help youth navigate these differences within their relationships.

How to help youth build communication skills to foster healthy romantic relationships

When helping young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work build communication skills to foster healthy relationships, youth-supporting professionals should:

- Model healthy communication and problem-solving skills.[40,41]
- Help youth practice communicating in healthy and productive ways (e.g., considering emotional expression, tone).[42]
- Encourage youth to reflect on past relationship conflicts or communication breakdowns and develop standards for healthy communication based on their experiences.[43]
- Acknowledge that more youth than ever are relying on online communication to either identify potential partners (e.g., online dating)[44] or communicate with partners (e.g., direct messages on social media).[45]
- Encourage youth to consider their romantic and sexual communication online and develop norms for

using social media, dating apps, and engaging in sexting.[46] This may involve creating boundaries for online communication and practicing saying "no"[47] to a request that violates those boundaries.

- Encourage youth to think about how they communicate consent, develop an understanding of how they will demonstrate affirmative consent, and give them the tools to have ongoing conversations about consent.[48] Consent is a central component of any healthy relationship and effective communication is an important part of establishing initial consent and continuing to discuss consent throughout a relationship.
- Encourage youth to take initiative and start hard conversations when needed.[49]
- Work with youth in a way that is nonjudgmental and supportive when they are describing their experiences.[50]
- Encourage youth to establish boundaries and norms around communication expectations with partners.[51]
- Work with youth to hear and listen to what the other person is saying.[52]

Boundaries/limits

Studies show that healthy relationship programming for adolescents generally improves their ability to differentiate between characteristics of healthy and unhealthy relationships, and to recognize the important role of boundaries.[53-55] In romantic relationships, boundaries constitute individuals' expectations and limits of what behaviors are acceptable or not acceptable of themselves and their partner(s). Boundaries help youth express to their partner(s) what they need to feel content and safe in a relationship and help their partner(s) understand how they can support the relationship.[56,57] Setting effective boundaries requires youth to express their own needs and limits and be open to listing and respecting boundaries set by their partner(s).

Boundaries can take many forms, but most sources identify four main categories: physical, material, mental/intellectual, and emotional.[58]

1. **Physical boundaries** are an individual's boundaries related to their body, which include sexual boundaries. These boundaries include the kind and level of touch they find acceptable, as well as how and when they are comfortable sharing space. Examples of physical boundaries include the amount of physical space a person wants in private and in public, whether they feel comfortable with affection in public, and whether they prefer spending time alone without their partner(s).[59]

2. **Material boundaries** are an individual's boundaries regarding their resources and belongings. They include whether and to what extent an individual is comfortable sharing or loaning things like money, clothing, vehicles, or cell phones.[60]

3. **Mental or intellectual boundaries** are an individual's boundaries about values, opinions, and beliefs. Individuals have different sets of values and beliefs that serve as guiding principles behind their decisions, actions toward others, and understandings of the world.[61] Mental boundaries may include values that an individual feels are especially important, such as trust and honesty.[62] Individuals may also set boundaries related to political beliefs.

4. **Emotional boundaries** are boundaries related to someone's emotions and include boundaries about when and what personal information they share.[63] For example, an individual may be comfortable sharing impactful or traumatic experiences from childhood, or they may prefer to maintain their privacy.[64] Similarly, an individual may be comfortable or uncomfortable with others sharing highly emotional and detailed experiences with them.[65]

Boundaries are rooted in what individuals find comfortable or uncomfortable and are highly individualistic: Everyone has different boundaries based on their experiences in life and relationships, both romantic and nonromantic.[66] Young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work may not have the information or experience to set appropriate boundaries.[67-69] Healthy relationship curricula and programs have been shown to help youth understand the importance of boundaries and establish limits that support their own needs. For example, a recent evaluation of a healthy relationship workshop found that "vulnerable youth" who attended the workshop had an increased ability to identify unhealthy relationship characteristics and to set and enforce boundaries.[70] In addition, the curriculum helped vulnerable youth practice saying "no" and clarified for youth that it may feel selfish to establish boundaries, but that it is necessary to assess and address one's needs.

The research and practice resources cite communication[71-73] as the most effective strategy to establish boundaries. Strategies can include partners asking each other clear questions about what they are/are not comfortable with (e.g., "Are you okay when…?" and "Are there things you aren't comfortable with when…?"), not making assumptions about partners, and not pushing one's views onto partners. As with recommendations on setting boundaries, however, resources on healthy relationships recommend holding others accountable by clearly communicating when a boundary is crossed, the consequences for crossing a boundary, and following through on that consequence.[74] Relationships may be unhealthy if a young person's boundaries are ignored, minimized, or disrespected by a partner.[75]

Systemic and cultural considerations for setting and enforcing boundaries in healthy romantic relationships

Norms associated with boundary-setting vary across cultures. For decades, research has explored how growing up in either collectivist or individualist cultures impacts one's expectations of themselves, their partner(s), and others (e.g., parents, caregivers, family members, friends) in romantic relationships.[76,77]

For example, the culture in which an individual grew up may influence their understanding and preferences related to autonomy or interdependence.[78] If one partner grew up in a collectivist culture, they may expect to spend most of their time with their partner(s) and do things together, whereas someone who grew up in an individualist culture may want more autonomy and independence in a relationship.[79] Youth-supporting professionals should work with youth to understand the different ways in which culture influences relationships and how to navigate differences with their partner(s). Furthermore, young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work may experience additional barriers to setting boundaries due to their experiences and may feel powerless or blamed for not having boundaries.[80-82] Therefore, youth-supporting professionals should not blame or judge them for a lack of boundaries and should instead focus on empowering them to work toward establishing boundaries for future relationships.

How to help youth set and reinforce boundaries in healthy romantic relationships

- Research and practice tools indicate that youth-supporting professionals helping young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work set and enforce boundaries should consider encouraging youth to:
- Explore answers to questions about their physical, material, mental, and emotional boundaries, such as:[83]
    - "Would I be okay with physical touch when I'm not expecting it?" or "What kind of physical touch or intimacy am I comfortable with in this situation/with this person?"
    - "Is it okay if my partner uses my phone?"
    - "Do I want to share social media passwords?"
- Reflect on past experiences when they did set boundaries or wished they had set boundaries.84
- Think about boundaries related to language, such as words to use for body parts. This may be especially important for transgender and nonbinary youth.[85]
- Check in with their partner(s) often on whether boundaries are being respected and upheld, rather than assume how their partners feel.[86]
- Consider how to respond if a partner violates one of their boundaries.[87]
- Take responsibility for crossing boundaries when/if that occurs.[88]

Shared power

Healthy relationships require equity—in this context, reciprocal and shared power, including support, respect, and personal agency. Equity in relationships helps prevent negative relationship outcomes such as dating violence[89,90] and is a focal topic among several relationship interventions.[91,92]

Elements of equity within relationships include an equitable provision of support between partners, a sense of fairness, and mutual respect.[93,94] Research on the skills that promote healthy romantic functioning in young adults found that those who demonstrated more mutuality—or consideration of the needs of others as well as one's own needs—tended to feel more secure and satisfied in their relationships.[95] One study found that adolescents in relationships characterized by more supportive interactions with their partner(s) exhibited better mental health nearly a decade later.[96] Lower satisfaction with the division of decision making in a relationship is a risk factor for negative relationship outcomes, including victimization by one's partner.[97]

Existing societal inequalities or differences in life and romantic experience levels can create power dynamics that challenge equity in relationships. Many youth experience a real or perceived disadvantage to their power within a romantic relationship. These power dynamics may include situations where partners have 1) a large gap in age or experience in romantic relationships;[98] 2) differences in wealth, income, or the stability of their living situation;[99] and 3) differences in social networks and support (e.g., if one partner is not "out" to colleagues, friends, or family).[100] Such power imbalances can make one partner susceptible to unhealthy relationship dynamics such as unhappiness and lower trust,[101] increased sexual risk behaviors,[102] or even threats to their well-being (e.g., dating violence).[103] Such power differences do not exist in isolation; in fact, multiple power dynamics may compound to tilt the balance more strongly toward one partner.

Systemic and cultural considerations to help youth enhance equity/power-sharing in healthy romantic relationships

Romantic relationships exist in the context of gender inequity, bias against LGBTQ+ relationships, and racism in society. For example, even among adolescents who profess that they want to be in a gender-equal relationship, adolescents face pressure to fill gendered roles: masculine toughness and sexual experience, feminine caretaking and controlled sexual availability.[104] Current research indicates that, when adolescents hold more gender-egalitarian beliefs, they endorse fewer harmful myths about romantic relationships, experience less hostility and violence, and have higher overall relationship quality.[105]

How to support youth and foster equity/power-sharing in healthy romantic relationships

For adolescents and young adults, romantic relationships that are mutually supportive and balanced across partners are more secure and rewarding[106] and have better implications for youths' well-being.[107,108] However, discussing equity in relationships may be a difficult subject. Adolescents may feel self-conscious or defensive about an unequal or power-imbalanced relationship they are in. Youth-supporting professionals may want to avoid stating or implying that a young person who experiences the child welfare and/or justice systems, homelessness, and/or disconnection from school and work is on the receiving (or benefiting) end of a power imbalance.

Instead, consider asking guiding questions such as:[b]

- In what ways do you support your partner(s)? How do your partner(s) support you?
- Do you and your partner(s) feel safe to express your needs and wants?
- Are you happy with how balanced your relationship feels?
- Based on this research and existing evidence-based practice tools on healthy relationships identified in this summary, youth-supporting professionals may need additional tools for working with young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. The tips for working with youth presented here are a starting point for these conversations.

[b] These are informed by a body of literature but are not attributed to a specific source. Rather, based on all research reviewed, the authors developed these guiding questions.

Methods

This research and evidence-based resource summary utilized a multi-step process to identify the topic, conduct the literature and resource scan, and obtain stakeholder input on content. We've detailed the process below:

1. First, we solicited feedback from a group of youth-supporting professionals, program administrators, and researchers during a focus group. During this focus group, we presented the broad topic of healthy relationships and asked about professionals' top needs in the field when working with youth. Based on this group's feedback, we decided to focus on healthy romantic relationships.

2. Next, we conducted a literature search focused on identifying systematic literature reviews and meta-analyses on the components of healthy romantic relationships.

    a. We developed the following key search terms: Foster youth, youth in foster care, child welfare, homeless youth or young adults, unhoused youth or young adults, opportunity youth or disconnected youth, and disconnected from work and school.

    b. We then searched each of those terms with each of the following: Healthy OR unhealthy relationships, healthy OR unhealthy dating, healthy OR unhealthy bonds, healthy OR unhealthy partner or partnership, romantic relationships, and social skills.

    c. This yielded 54 results, with 34 of those results meeting the criteria of being a meta-analysis or systematic review; these results were therefore screened in.

3. We used the results of the initial literature scan to create a short survey to ask youth-supporting professionals to identify the top three components of healthy romantic relationships they saw as most important to include in the resource.

4. Once we narrowed down the top three components, we went back to the literature and conducted a scan focused on systematic literature reviews, meta-analyses, and evidence-based resources—both among youth broadly and specifically among young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. We then repeated this process to identify evidence-based resources:

    a. We developed the following key search terms: Foster youth, youth in foster care, child welfare, homeless youth or young adults, unhoused youth or young adults, opportunity youth or disconnected youth, and disconnected from work and school.

    b. We then searched each of those terms with each of the following: Healthy OR unhealthy relationships, healthy OR unhealthy dating, healthy OR unhealthy bonds, healthy OR unhealthy partner or partnership, romantic relationships, and social skills.

    c. This yielded 70 results which were screened in and reviewed for this research summary and an additional 30 evidence-based resources that were screened in and reviewed for this summary.

5. Next, we reviewed the screened results of the literature scan and summarized the findings in this resource.

6. Last, we had a group of youth-supporting professionals, program administrators, and researchers review the brief, after which we incorporated their feedback.

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About the Authors

Rachel Rosenberg is a senior research scientist at Child Trends and a member of the Activate project team.

Karlee Naylon is a research analyst at Child Trends and a member of the Activate project team.

Katelyn Rust is a senior community liaison at Child Trends and a member of the Activate project team.

Samuel Beckwith is a senior research analyst at Child Trends and a member of the Activate project team.

Nia-Simone Woods is a senior research assistant at Child Trends and a member of the Activate project team.

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Crucial Conversations about Healthy Romantic Relationships

A Toolkit for Youth-Supporting Professionals

Rachel Rosenberg, Karlee Naylon, Nia-Simone Woods, Katelyn Rust, and Samuel Beckwith

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Introduction

Crucial Conversations About Healthy Romantic Relationships focuses on three critical domains[1] of healthy romantic relationships[1]: communication, such as sharing thoughts/feelings; boundaries/limits, including setting, enforcing, and respecting boundaries and limits; and shared power, such as negotiating roles and responsibilities.

This toolkit is for you: professionals who support teens and youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. **The Toolkit has four sections that can be used together or as standalone tools to help you with the following**:

- **Lay the foundation for talking to young people about healthy romantic relationships**—Includes helpful tips and groundwork that may be needed while talking with teens about healthy romantic relationships (page 2).
- **Start conversations with youth about healthy romantic relationships**—Includes strategies for starting the conversation, continuing the conversation, and checking in after the conversation (page 4).
- **Know the dos and don'ts for talking with teens and youth about healthy romantic relationships**—Includes a list of things to consider doing, or to avoid, while talking with youth about healthy romantic relationships (page 9).
- **Identify additional resources** to help you support youth to have healthy romantic relationships (page 11).

**Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals* bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

This tool is based on a research summary from Activate* which describes healthy romantic relationships and youth well-being. Healthy romantic relationships are developmentally appropriate during adolescence and young adulthood.[2,3] Young people who engage in healthy relationships may experience better outcomes such as decreased mental health concerns, higher overall life satisfaction, and higher self-esteem.[4] However, young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work may be at an increased risk for unhealthy romantic relationships, such as abusive relationships and those that involve sexual exploitation.[5–7] This increased risk may be due to:

- Limited experience observing and experiencing healthy relationships[8–10]
- General instability in housing and school, which may create instability in relationships[11]
- Experiences with trauma associated with instability, systems-involvement, homelessness, and/or disconnection from school[12–14]

You can use this toolkit to help youth understand the components of healthy romantic relationships, navigate conversations with partner(s), and identify where to turn for support if they are in an unhealthy romantic relationship.[15] Although the toolkit focuses on romantic relationships, much of its guidance applies across types of relationships (e.g., relationships with friends, peers, adults, parents).

[1] The domains were identified by a group of young people with lived expertise, program administrators and direct service providers who support them, and other experts on sexual and reproductive health working with systems-involved youth, youth experiencing homelessness, and disconnected youth.

Laying the Foundation to Talk to Young People About Healthy Relationships

When talking with youth about healthy romantic relationships, consider how well you are prepared for the conversation.[16] This tool outlines six conditions that may help you talk to young people about healthy relationships, why those conditions are important, and how you can cultivate these conditions for the youth you support.

You can establish the foundation for talking to young people about healthy relationships when you:

1. Develop rapport and trust with the young person.
2. Create a welcoming and private space.
3. Prepare for, engage in, and follow up with youth intentionally.
4. Remain self-aware and willing to reflect on your own assumptions.
5. Maintain your knowledge of state-mandated reporting policies.
6. Pay attention to cultural norms.

For more information on laying the foundation for talking about healthy relationships with youth, see section four of this toolkit: *Additional Resources for Talking With Youth About Healthy Romantic Relationships.*

Conditions for laying the foundation for talking with youth

Condition 1: Rapport and trust with the young person	
Why is this condition important?	**How do I create the condition?**
Build rapport and trust with a young person to ensure they feel heard, understood, and supported. Trust helps youth feel comfortable discussing healthy relationships.[17]	Trust and rapport are built over time. You can build trust and rapport when you 1) actively listen, 2) respond without judgment, and 3) show authenticity. You can help empower, advocate for, and guide youth through challenging situations in their relationships.[18,19]

Condition 2: A welcoming, private space	
Why is this condition important?	**How do I create the condition?**
A welcoming and private space can help youth feel comfortable talking about themselves and their romantic relationships.[20,21]	Reduce distractions that can cause anxiety (e.g., visual, auditory, and motion over-stimulation).[22,23] Create opportunities for youth-led individual or group sessions and for youth to express themselves creatively (e.g., through art or play). [24,25]
Condition 3: Intentionality in preparing for, engaging in, and following up with youth	
Why is this condition important?	**How do I create the condition?**
Be intentional in how you approach interactions with youth. Help youth have an honest and open dialogue.[26]	Ensure that time with youth is meaningful. Plan topics ahead of time but prioritize allowing youth to drive what is most important.[27] Work with youth to set an agenda, ask specific and open-ended questions, set goals, and provide resources and/or homework between interactions.[28]
Condition 4: Self-awareness of assumptions	
Why is this condition important?	**How do I create the condition?**
Self-awareness helps you understand your emotions, biases, strengths, and areas for growth in conversations with young people.[29,30]	Take steps to develop greater awareness of your own strengths, challenges, and areas for growth. Engage in ongoing professional development and learning (e.g., work-related professional development resources, case conferencing, and/or clinical supervision if available). [31,32,]
Condition 5: Knowledge of state-mandated reporting policies	
Why is this condition important?	**How do I create the condition?**
Be clear with youth about what you legally must report to authorities (e.g., abuse) when disclosed. This ensures that youth feel comfortable having open and honest conversations.	Learn mandated reporting policies in your state. Have conversations about those policies with youth. [33]
Condition 6: Awareness of cultural norms	
Why is this condition important?	**How do I create the condition?**
Talk with youth about differences in cultural norms related to healthy relationships. Work with youth to navigate their own cultural beliefs and those of their current and future partner(s).[34]	Talk about differences in communication styles, gender norms, and views of healthy romantic relationships. For example, some cultures rely on verbal and nonverbal cues while others just focus on verbal cues.[35]

Conversation Starters for Talking With Youth About Healthy Romantic Relationships

Communication, boundaries/limits, and shared power are key components of healthy romantic relationships that are critical for young people who experience the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work—according to the young people and youth-supporting professionals who advised this work.

You can use these conversation starters to initiate discussions with young people. For each component—communication, boundaries/limits, and shared power—you will find a definition and suggested conversation prompts to help you start the conversation, continue the discussion, and follow up after the conversation. These prompts are not exhaustive.

Communication

Communication is how partners in a relationship express their thoughts and feelings, both verbally and nonverbally.[36,37] Healthy communication includes active listening, honesty, emotional regulation, and self-awareness.[38,39] Preferences and styles may vary from youth to youth depending on culture and experiences.[40–42]

Experience in the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work may limit young people's opportunities to learn communication skills and practice these in safe relationships with parents, siblings, and friends due to frequent moves or unstable placements. Through these conversation starters, you can help young people reflect on their communication styles and strengthen their verbal and nonverbal communication skills.

Use these conversation starters to talk with youth about communication in their romantic relationships.[2]

Communication	
Active listening	
Getting started	• What does active listening look like to you? In other words, how does someone show that they are really listening to you?
Continuing discussions	• How would you approach a discussion with your partner(s) if you wanted them to listen to you more actively? • Have you and your partner(s) discussed words or actions that signal you are actively listening to one another?
Following up	• How have you and your partner(s) used active listening since we last spoke?

[2] All prompts in this document are informed by the research literature on healthy romantic relationships.

Communication	
Honesty about wants and needs	
Getting started	• In what ways are you honest with your partner(s) about your wants and needs?
Continuing discussions	• What wants and needs are easier or more difficult to be honest about? What barriers are there to being honest? • How might you let your partner(s) know they can be honest with you? • How can you prepare yourself and respond when you have an honest conversation about wants and needs that involves difficult topics?
Following up	• How are you feeling about the amount of honesty about your wants and needs within your relationship(s) since we last talked?
Nonverbal communication	
Getting started	• What kinds of nonverbal cues do you use when you communicate with your partner(s) (e.g., eye contact, hand movement, direction you face)?
Continuing discussions	• What nonverbal communication cues do you use that help you have good conversations with your partners(s)? • What nonverbal communication cues do you use that may challenge your conversations with your partner(s)? • What nonverbal communication cues do you notice your partner(s) using when they communicate with you?
Following up	• How have you changed how you communicate using nonverbal cues with your partner(s) since we last spoke?

Boundaries/limits

Boundaries/limits are an individual's expectations and limits of what behaviors are acceptable or not acceptable within their relationships.[43] Individuals generally have physical, material, mental or intellectual, and emotional boundaries/limits.[44] Understanding and recognizing boundaries/limits is essential for establishing and maintaining a healthy romantic relationship. Healthy boundaries/limits allow youth to feel comfortable with expectations in their relationships.[45]

Time spent in the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work can leave young people with little control over how they are treated in those relationships and their lack of autonomy within those relationships.[46] Therefore, youth may have less practice establishing boundaries/limits in relationships and need additional help figuring out their boundaries/limits and communicating those to other people.

Use the conversation starters on the following page to talk with young people about boundaries/limits in their romantic relationships.

Boundaries and Limits	
Establishing boundaries/limits	
Getting started	• When you and/or your partner(s) set a boundary or limit, how do you show you respect that limit?
Continuing discussions	• What is an example of a boundary/limit that you set and your partner respected? • How comfortable are you talking to your partner(s) about boundaries/limits you want them to better respect? What helps you feel more comfortable with setting a boundary or limit? • What does considering your partner(s) boundaries/limits look like to you?
Following up	• Since we last spoke, what boundaries have you set with your partner and how were those boundaries respected?
Physical boundaries	
Getting started	• How do you know your partner(s) respect your physical boundaries?
Continuing discussions	• How do your partner(s) check in on your comfort with your physical boundaries? • How do your partner(s) react when you say no or share you are uncomfortable? What are some ways you can talk with them about how you would like them to change? • How do you react and change when your partner tells you no or shares they are uncomfortable?
Following up	• In what ways have you and your partner(s) further discussed what is off limits or uncomfortable for each of you?
Personal belongings	
Getting started	• How do your partner(s) show they know and follow your boundaries for using your personal belongings and/or those related to personal information, such as asking for your password for social media or monitoring your social media?
Continuing discussions	• How did you and your partner(s) determine your boundaries around personal belongings and personal information? • How can you discuss boundaries around using your personal items and information with your partners? • In what ways can you discuss your partner(s)' boundaries around the ways you use their personal items and information? • How might discussing your boundaries change your relationship with your partner(s)?
Following up	• How have you and your partner(s) demonstrated understanding and respect for your boundaries in sharing personal belonging and information since we last spoke?

Shared power

Shared power means that partners in a relationship support and respect one another and have balanced, mutually agreed-upon roles and responsibilities.[47–49] People in relationships with shared power tend to be more satisfied in their relationship and may experience better mental health.[50]

Talking about and understanding shared power in romantic relationships is complex. For example, shared power is influenced by behaviors and biases related to numerous factors such as gender identity, sexual orientation, race, and disability status.[51] Youth experiencing the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work may have limited examples of shared power in relationships due to a lack of stability in their homes and living arrangements and few opportunities to openly discuss power-sharing.

Use these conversation starters to talk with young people about shared power in their romantic relationships.

Shared Power	
Input in decision making	
Getting started	• What are some examples of the input you have or want to have when making decisions?
Continuing discussions	• When you are having a conversation or making a decision with your partner(s), what kind of input do you want to have? • How comfortable are you talking with your partner(s) about the kind of input you have (e.g., spending time together and apart, day-to-day decisions, or decisions about sex and contraception)? • Do you think your partner(s) have the input in decision making they want? Why?
Following up	• How has the input in decision-making with your partner(s) been since we last spoke?
Influence of societal pressure and/or bias	
Getting started	• How do societal pressures or biases such as those related to gender identity, sexual orientation, race, religion, or ability affect how you share power in your relationships?
Continuing discussions	• How comfortable are you talking to your partner(s) about how gender identity, sexual orientation, race, or ability affect power sharing in your relationships? • What do you and your partner(s) do to prevent biases or societal pressures from affecting power sharing in your relationships?
Following up	• How have you and your partner(s) talked about how biases or societal pressures affect how you share power in your relationships since we last talked?

Shared Power	
Agreement about power sharing	
Getting started	• In your relationship(s), how do you discuss and come to a mutual agreement about roles and power when making decisions?
Continuing discussions	• In what ways do you have mutual agreement, such as how you spend time together, who you spend time with, or decisions about sex and contraception? • In what areas do you and your partner(s) lack agreement or have an imbalance? • How comfortable are you describing your concerns and negotiating a change if roles and power become unbalanced? How would you start a conversation about an imbalance of power with your partner(s)?
Following up	• How have you and your partner(s) experienced and discussed roles and power dynamics in your romantic relationship(s) since we last spoke?

Dos and Don'ts for Talking With Youth About Healthy Romantic Relationships

You can use these dos and don'ts to guide your conversations with young people about healthy romantic relationships. Approach each conversation with empathy, willingness to listen and learn, and commitment to improve.[3] For more information on dos and don'ts for talking with youth about healthy relationships, see section four of this toolkit: *Additional Resources for Talking With Youth About Healthy Romantic Relationships.*

The following list of recommendations is not exhaustive but provides a starting point for talking with young people about healthy romantic relationships:

- Create an open and judgement-free zone.
- Help young people explore their experiences rather than labeling them.
- Validate young peoples' feeling and experiences.
- Approach conversations with an open mind.
- Use a trauma-informed lens.
- Respect youth's privacy and be transparent about limits to transparency.

You can find examples about dos and don'ts for talking with youth about healthy romantic relationships on the next page.

[3] Factors such as cultural norms play an important role in conversations about healthy romantic relationships. For more information about cultural considerations to keep in mind when talking about healthy relationships with youth, see "Laying the Foundation."

Dos and Don'ts for Talking with Youth about Healthy Romantic Relationships

DOS	DON'TS
DO ask nonjudgemental, open-ended questions. *"Can you walk me through the interaction and how it made you feel?"*	**DON'T** use language that can be interpreted by the young person as implying blame or shame. *"It might not have been productive to react like that. You probably should have reacted a different way."*
DO encourage youth to explore the spectrum of identities and feelings. *"It sounds like your partner may have made you feel unsafe or uncomfortable by doing that."*	**DON'T** rely on black and white labels. *"Your partner was being abusive toward you."*
DO validate feelings, experiences, and fear. *"Disagreements in relationships can be really stressful, and it's possible for partners to disagree about something without overstepping each other's boundaries."*	**DON'T** trivialize experiences, fears, needs, or wants. *"It's unrealistic to set a boundary to prevent disagreement or arguments from ever happening."*
DO ask the young person about their knowledge on a subject and fill in gaps. *"It can be difficult for someone to know if they're in an unhealthy relationship. What does a healthy relationship look like to you?"*	**DON'T** make assumptions or generalizations about what a young person does or does not know. *"Young people are too naïve and inexperienced to recognize when they're in an unhealthy relationship."*
DO understand that the young person did what felt safest for them in the moment and validate them. *"It can be really difficult to know what to do in that situation."*	**DON'T** ignore complexities of a situation. *"You should have left the relationship as soon as the problems started."*
DO tell youth what is private, as well as what must be disclosed (and when). *"I want you to feel safe sharing things with me, but there are things—like if someone hurt you or you are thinking about hurting someone else—that I'm legally required to report to authorities. We can talk more about that if you have questions."*	**DON'T** assume young people know what must be disclosed or that everything is confidential. *"Don't worry, everything you tell me will stay between us."*

Additional Resources for Talking With Youth About Healthy Romantic Relationships

You can use the resources below to access additional information about components of healthy relationships, building communication skills, boundaries/limits, and shared power.

Resource name and link	Resource description	Use this resource to …
National Healthy Marriage Resource Center, The Annie E. Casey Foundation, and Innovation Center for Community and Youth Engagement (2019) Relationships matter: Strengthening vulnerable youth	This report reviews the importance of healthy relationships among youth and how to discuss them with youth.	Gain knowledge and comfort about healthy romantic relationships.
John Hopkins University (2020). 12 elements of healthy relationships	This blog explores elements of healthy relationships and provides links to resources for additional information.	Gain additional examples of how to talk with youth about healthy relationships.
Youth.Gov (n.d.). Characteristics of healthy and unhealthy relationships	This webpage describes characteristics of healthy relationships for teens and unhealthy relationship characteristics.	Gain knowledge of healthy relationships and signs of healthy and unhealthy relationships.
Forbes Health (2024). How to communicate in a relationship, according to experts	This article outlines different forms of communication and provides examples of good and bad communication. It also provides additional examples of conversation starters to use with youth.	Prepare for conversations with youth and see prompts for starting those discussions.
Positive Psychology (2024). How to Set Healthy Boundaries and Build Positive Relationships	This article defines boundaries, provides examples of healthy boundaries, and includes links to other helpful resources.	See examples of additional conversation starters to use with young people.
Therapist Aid (2016). What are personal boundaries?	This article provides different types of boundaries and characteristics of people within each boundary type.	Provide youth with examples of different types of boundaries and utilize the self-reflection questions in your work to help youth set boundaries.
Mass.Gov (n.d.). Boundaries in healthy relationships	This webpage provides components of healthy and unhealthy	Inform your work by reviewing additional

Resource name and link	Resource description	Use this resource to …
	relationships, provides guidance on how to think about and set boundaries, and offers conversation prompts to discuss boundaries with partners.	information on healthy and unhealthy relationship components.
OurPath (2021). Healthy boundaries for partners of trans people	This article provides information around boundaries during and after transition where one partner identifies as transgender.	Explore boundaries and considerations when working with youth who are transgender or whose partner(s) are transgender.
Eastland County Crisis Center (n.d.). Relationship Equality Wheel for Teens	This infographic provides information on different components of equality.	Talk through different elements of a relationship as they work through shared power in their relationships.
Love is Respect (n.d.). Power and Control	This webpage provides information on different power dynamics and ways that partners may control one another.	Review aspects of healthy and unhealthy relationships to explore potentially controlling behavior.
Love in Respect (n.d.). 4 things that make a relationship healthy or unhealthy	This blog provides information on characteristics of a healthy and unhealthy relationship. The resource provides different elements of shared power.	Identify different elements of shared power.

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Seeking, Giving, and Receiving Consent for Sexual Activity

Rachel Rosenberg, Matthew Rivas-Koehl, Brittany Mihalec-Adkins, Colleen Schlecht, Jenita Parekh, and Dane Rivas-Koehl

Introduction

Consent for sexual activity (hereafter referred to as consent) is the foundation for safe and respectful sexual activity. Consent is defined as voluntary, informed, and mutual agreement among those involved in sexual activity, conveyed through clear words or actions by individuals who are fully able[a] to make such a decision.[1,2] Research highlights that consent is an active, ongoing process that includes both the freedom to agree and the right to decline. This process has three interconnected processes:

1. ***Giving consent***—communicating one's willingness to engage in sexual behavior. Giving consent also includes communicating that one does not want to engage in sexual behavior.[3]
2. ***Seeking consent***—inquiring about whether one agrees to sexual behavior or learning the partner(s) does not agree, through verbal or nonverbal signs.[4]
3. ***Receiving consent***—the process through which an individual interprets whether they have received consent from another person and acts accordingly.[5,6]

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Throughout this summary, we refer to consent as agreement to engage in sexual activity. We also address the equally important decision to decline to engage in sexual activity.

Through a needs assessment about information and practice tools focused on sexual and reproductive health, youth-supporting professionals identified *consent for sexual activity* as a topic for which they need more knowledge to strengthen their work with young people. To address this gap, this resource summarizes research about forms of consent; communicating consent; seeking, giving, and receiving consent; and factors influencing consent behaviors among youth—both broadly and among youth experiencing the child welfare and/or juvenile justice systems, homelessness, and/or opportunity youth (i.e., disconnected from school and work). Professionals can use this summary to enhance their awareness about the components of consent and inform their work to support youth programs and young people.

There is limited research about consent focused on young people who experience the child welfare and/or justice system, homelessness, and/or disconnection from school and work. Therefore, we summarize research about consent from more general populations, which tends to focus on college-enrolled young people. We also include research about consent among young people who experience trauma and adversity. Young people who experience the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work experience a greater prevalence of trauma and adversities associated with sexual and reproductive health.[7,8,9,10] In addition, the research about consent is informed by diverse perspectives. The literature we describe is peer-reviewed, and our search focused on key words about consent such as sexual consent

[a] Fully able includes that one is free from coercion and not incapacitated.

education, consent for sexual activity, consent education, consent communication, sexual consent, teaching consent, and comprehensive sex*ed. See the section on Gaps in Existing Literature and Appendix A on Methods for more information about the literature included in this summary.

Key findings

- Young people who experience the child welfare and/or juvenile justice systems, homelessness, and/or opportunity youth are more likely to experience trauma. Youth-supporting professionals say they need trauma-informed resources to hold successful conversations about consent with young people.
- There are many definitions of consent. No definitions are universally accepted, but many have common attributes. Consenting individuals must be fully informed about the activity for which they are consenting and their potential partners' sexual health. Consenting individuals cannot be coerced and are able to give and revoke consent at any time.
- Sexual partners can communicate consent in many ways. Regardless of how they communicate consent, all parties must be clear about the agreement, or lack thereof, and respect that decision.
- Youths' histories and experiences (e.g., age, disability) may influence how they seek, give, and receive consent for sex.
- Context (e.g., substance use, social norms, relational factors) can influence consent behaviors and communications.

Why It's Important to Talk About Consent

Many—although not all—youth engage in sexual activity.[11] In 2023, 32 percent of high school students reported ever having had sex.[12] Studies of youth who experience the child welfare and/or justice system or homelessness generally find higher rates of sexual activity. Among youth in foster care, estimates range from 40-50 percent of youth who report ever having had sex by age 18.[13,14] Among high schoolers experiencing housing instability, 48 percent reported being currently sexually active.[15] Among young women in short-term juvenile justice facilities, up to 76 percent reported ever being sexually active.[16]

Sexual development is a normal part of adolescence. Youth begin to experience changes in their sexual development at puberty[17] and the median age of first intercourse for young people is 17 years.[18,19] However, social, psychological, developmental, and other factors may influence if and when individual youth engage in sexual activity.[20] Regardless of whether or not youth engage in sexual activity, they may find themselves increasingly in situations in which sexual activity is occurring or in which they must understand how to say no and decline to participate in sexual activity—and how to provide consent. Therefore, teaching about consent is developmentally appropriate for youth and ensures that they have knowledge to decline to engage in sexual activity until they are ready and, when they *are* ready, to engage in sexual activity safely.[21] For example, when youth wait to have sex until their late teens, they report higher rates of contraception use and experience lower rates of contracting sexually transmitted infections (STIs).[22] The lower risk for STIs is due, in part, to improved decision making and increased communication skills about consent and other aspects of sexual activity.[23] In addition, increasing knowledge of consent and the importance of receiving consent before moving forward with sexual activity might help prevent some forms of sexual violence.[24] However, effective sexual violence prevention programs must incorporate several elements, of which consent is just one. Consent alone is not enough to prevent most forms of sexual violence and only focusing on consent may inadvertently oversimplify sexual violence and blame those who have experienced sexual violence.[25]

Regardless of when (or if) youth become sexually active, there are several skills that can help them make consent-related decisions.[26] Youth with strong emotional regulation[27,28] and self-efficacy[29] may be more comfortable during the decision-making process and more capable of communicating their decision with potential partners. Conversely, experiences of trauma may challenge youths' ability to provide consent and have unique implications for how youth seek, give, and perceive consent.[30,31] Disproportionately high rates of youth who experience the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work experience traumatic events and residual trauma-related symptoms and behaviors.[32,33] Therefore, a trauma-informed lens can generally support young people with these experiences while also building on their unique strengths.

Young people experiencing the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work may miss critical information about consent when schools are the primary setting for addressing the topic of consent—whether through sex education, sexual violence prevention education, or healthy relationship education—as many experience instability in school settings,[34,35] frequent changes in placement/living arrangements,[36] and a lack of consistent relationships with supportive adults.[37,38] Further, foster caregivers, caseworkers, and other supportive adults report not being equipped to talk with youth about sex education or report that they don't see it as part of their duties.[39] Yet for young people in the child welfare system, caseworkers are often a primary source of information about sex education.[40] Additionally, research about professionals who support youth who experience the juvenile justice system finds that these professionals report several barriers to providing access to sexual and reproductive health resources, including laws that limit what can be taught, the absence of laws requiring anything to be taught, a lack of access to appropriate information, and personal views that influence what one is willing or able to talk about with youth.[41]

Consent is an active, ongoing process, with both internal and external components influencing whether one provides consent for sexual activity or declines sexual activity. Consent can be reversed at any time, and agreement to sexual activity at one point in time does not imply an indefinite agreement (consent) for sexual activity.

Willis, M., & Jozkowski, K. N. (2019). Sexual precedent's effect on sexual consent communication. *Archives of Sexual Behavior*, *48*, 1723-1734.

In a scan of the literature describing sex education curricula designed specifically for youth experiencing the child welfare and/or juvenile justice systems, homelessness, or disconnection from school and work, we identified eight research- and evidence-based curricula that might help youth-supporting professionals talk with youth about consent (see Appendix A for more information about curricula). The curricula provide youth-supporting professionals with skills to talk with youth about consent and other communication skills related to sexual activity. Education about consent and communication related to sexual activity is critical, as youth who feel more informed about sex are more likely to view asking for and receiving consent as important.[42] Of the eight curricula, two (Thrive and Teen Talk Foster Youth) directly discuss consent, while another three discuss communication skills related to sexual activity but do not specify whether consent is covered in the communication skills taught. Although the curricula are evidence-based, none of the studies directly evaluate whether the components on consent are directly linked to positive outcomes such as decrease in sexual violence, increase in trust in the relationship, increased comfort in negotiating consent, or increased knowledge of seeking and receiving consent.

Definition of Consent

Consent is defined in many ways. We use a combination of legal and practical definitions to define consent. As stated earlier, consent is defined as a voluntary, informed agreement among those involved to engage in sexual activity, conveyed through clear words or actions by individuals who are fully able[b] to make this decision.[43,44] Given that we describe consent as a decision reflecting agreement to engage in sexual activity, we also include the decision to decline to engage in sexual activity throughout the brief. Both decisions are equally important.

Forms of consent

The definition of consent includes three forms of consent: external, internal, and legal. *External consent* involves clear communication about whether one agrees to engage in sexual activity.[45] Additionally, young people may decide to decline to engage in sexual activity and communicate that decision with their partners, both verbally and nonverbally. *Internal consent* is the way one feels and thinks about their affirmative decision to engage in sexual activity, which requires reflecting on one's feelings, values, comfort levels, and beliefs.[46,47] Young people may also decline to engage in sexual activity if they think or feel negatively about engaging in sexual activity. Internal consent requires youth to explore their own feelings and recognize that those feelings are highly contextual and may change in different situations.[48]

Consent requires sexual partners to perceive and comprehend decisions of whether to engage in a particular activity at a particular time (i.e., receiving consent).[49] Partners may communicate and perceive external consent using both verbal and clear, voluntary nonverbal cues. An example of verbal consent is providing an enthusiastic, verbal "yes" to a partner.[50,51] Verbal responses can also be combined with clear, voluntary nonverbal cues (e.g., saying "yes" while also leaning into another person or saying "no" while pulling away). Research shows that, when giving consent that relies on verbal communication and when seeking consent, verbal clarifications are the best way to reduce ambiguity.[52] Young people who have experienced traumatic events may not show the same level of assertiveness in refusing unwanted sex,[53] indicating that youth-supporting professionals may need to talk with youth about how to be assertive in saying "yes" or "no" and how to manage and respond to receiving a no or lack of consent from a perspective partner. Further, youth who have experienced trauma may face additional barriers to communicating their external consent in a way that matches their internal consent. For example, feeling pressured to please a partner, regardless of one's own desires, is a common response for those with a history of childhood sexual abuse.[54] Further, some survivors of sexual violence report reduced interest in sex, not feeling comfortable in their bodies, and experiencing anxiety or panic during sexual activities.[55,56] Some survivors of sexual violence may avoid intimacy or experience a disconnect between their internal consent and what they express verbally.[57]

Young people must respect verbal and nonverbal consent during all sexual activity. Further, any indication that a potential partner does not want to engage in sexual activity requires everyone to pause, clarify whether the activity should proceed, and then stop if needed.[58] Consent can be complex when internal and external consent do not align. For example, a young person's outward communication (e.g., saying "yes" or "no") may not align with their internal feelings due to factors such as coercion, aggression, or stereotypes and norms.[59,60] If a young person verbally agrees but hesitates or seems unsure, it is their partner's responsibility to get clarification about whether consent was provided.[61] Acknowledging the complexities and nuances of consent is not a validation of harmful myths (e.g., "they said no but really mean yes"). Rather, these complexities highlight why many consent education frameworks ("yes means yes") oversimplify the consent process and may fail youth who experience barriers (e.g., coercion, intimidation) to declining to

[b] Fully able means that one is free from coercion and not incapacitated.

engage in sexual activity safely.[62] The next section includes more information about the complexities and nuances of external and internal consent.

Legal consent

Legal definitions of consent often focus on external consent—what is communicated (or not) to the other parties and each partner's ability (or not) to consent. Legal definitions are typically based on factors like age and scenarios such as being asleep or unconscious and/or being intoxicated (either voluntarily or involuntarily) to the point of incapacitation, partial consciousness, or lacking of awareness of one's surroundings.[63] Importantly, any form of sexual activity that occurs without the consent of all partners is considered a form of sexual violence,[64] with consequences and legal ramifications varying across states, ages, and types of sexual activity (e.g., statutory rape, rape, unwanted kissing).[65]

Youth-supporting professionals should be aware of their states' mandatory reporting requirements, which legally require them to report disclosures from youth under age 18. For example, in some states, professionals are obligated to report if a youth discloses any sexual activity with an adult, even if the youth describes the activity as consensual. Further, in some states, reporting may be required depending on the youth's age (e.g., age 13 and under) or if their partner is more than three years older than them (e.g., ages 14 and 17). Most states require reporting any sexual activity described as coercive or unwanted, regardless of the age of the person(s) involved. See the Complexities and Caveats section below for more information.[c]

There is considerable variation in states' legal definitions of consent, how the definitions account for internal consent, and what constitutes coercive behavior in seeking and receiving consent.[66] Additionally, legal definitions of consent may not account for scenarios that are unique to youth experiencing the child welfare and/or juvenile justice systems, homelessness, or disconnection from school and work. For example, youth who experience the child welfare system have high rates of lifetime sexual abuse (estimates range up to 27%).[67] These experiences of trauma can affect how youth respond in sexual scenarios involving seeking, giving, and receiving consent.[68] Legal definitions may not address the nuance of consent—or what happens internally before a young person communicates how they are feeling.

Communicating Consent

Effective consent communication involves both giving consent and receiving consent—or understanding that another person is consenting (or not) to sexual activity.[69] As described throughout this summary, part of communicating consent can also include the opposite of consent—that is, *declining* to engage in sexual activity.[70] Young people often use a combination of verbal and nonverbal indicators of consent.[71,72] Research on consent stresses the importance of seeking, giving, and receiving an active and explicit agreement (e.g., "yes") before engaging in sexual activity.[73,74] The research also stresses the importance of youth feeling empowered to say "no" and declining to engage in sexual activity.[75] Further, positive experiences with communicating consent (both seeking and giving) can increase trust, respect, and safety in relationships.[76]

[c] For more information on state's mandated reporting requirements, please see the following two citations. The National Center for Youth Law summarizes key information on age of majority and access to reproductive services and the ASPE report provides a breakdown of different components of mandated reporting by state.

Verbal consent

Verbal consent is a form of external consent that involves using direct spoken communication to give and receive consent to engage in sexual activity.[77,78] Verbal communication may also be used to indicate that one does not consent to sexual activity. For example, someone may state, "I don't want to do that" or "Stop."[79] Females ages 14 to 24 are more likely to rely on verbal forms of sexual communication for both seeking and giving consent and refusal, relative to males in the same age range.[80] Other, less explicit forms of verbal consent may include explicitly sexual verbal signals, such as verbal responses to pleasure.[81] Less explicit forms of verbal consent may create ambiguity in the situation; if anyone involved is unsure of whether consent was provided, they should ask for more explicit verbal consent to reduce confusion.[82] When any person engaged in sexual activity is unclear on whether consent was provided, they must pause and seek clarity before moving forward and respect the decision provided. Consent requires mutual agreement from everyone involved in sexual activity.[83] Further, sexually suggestive text messages and/or images can also increase ambiguity around consent, with varying perceptions of consent given and received through sexually suggestive texts.[84]

Importantly, individuals who have experienced traumatic sexual events and those experiencing ongoing post-traumatic stress symptoms may experience additional barriers to communicating consent or their disinterest in sexual activity.[85] Research about ambiguity and coercion in consent is helpful for understanding more about consent among individuals who experience trauma. Individuals may interpret one's tone or wording differently, and these differences in interpretation may influence one's understanding of consent. For example, some males may interpret a female's friendliness toward them as indicative of sexual interest (for more information on differences related to sex, see the section on individual characteristics).[86] Verbal consent is also complicated to understand in situations in which a person may provide a verbal agreement to engage in sex, but feel pressured to do so.[87] A person has not provided consent if they feel coerced to say "yes,"[88] underscoring the importance of youth understanding both internal and external consent when giving, seeking, and receiving consent.

Nonverbal consent

Nonverbal consent involves actions and body language cues to indicate one's agreement to engage in sexual activity.[89] Research demonstrates that young people more frequently use nonverbal consent cues than verbal consent.[90] Nonverbal consent may be expressed through positive displays of body language such as smiling, nodding, and leaning into another person; by contrast, nonverbal cues of withholding consent include[91] displays of not wanting to engage, such as moving someone's hand and shifting body positions to reduce access.[92] Nonverbal sexual communication can be ambiguous, increasing the likelihood of misinterpretation.[93] Therefore, researchers recommend that youth communicate with their sexual partners in multiple ways that combine both nonverbal and verbal communication to clearly express consent and mutual agreement to engage in sexual activity.[94] Further, those seeking and receiving consent should pause and ask for clarification if they are unsure whether they received consent, and should respect the decision they are provided.

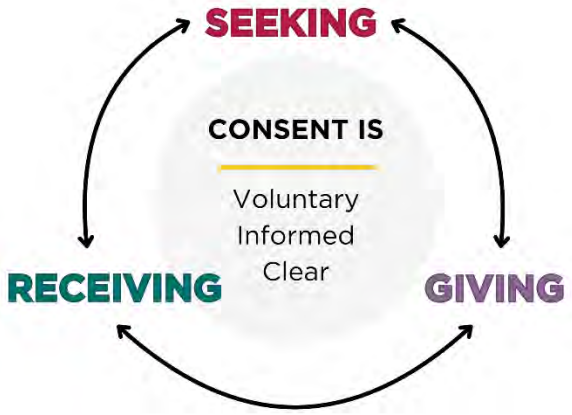
Youth who have experienced trauma may have unique experiences during sex that impact their ability to provide verbal or nonverbal consent. For example, research shows that survivors of sexual violence report physical arousal during the assault, which is a bodily response and not an indicator of nonverbal consent.[95] Furthermore, disassociation (i.e., mental or emotional detachment from one's body, thoughts, or surroundings)[96] related to trauma may also influence consent. People with a history of childhood maltreatment demonstrate higher levels of dissociation than their peers.[97] Although dissociation can be a protective mechanism that helps people survive traumatic experiences,[98] dissociation during later sexual encounters can complicate one's ability to provide consent.[99] Sensory stimuli during sex can trigger memories of the abuse, and people may react by dissociating in order to continue sex.[100] In addition, young

adults with chronic maltreatment histories may have "fight, flight, or freeze" responses triggered more easily than young adults with no or nonchronic maltreatment histories.[101] Further, young people who have experienced trauma may experience an increased risk of "freezing" or disassociating in subsequent sexual encounters.[102,103]

Seeking, Giving, and Receiving Consent

Seeking, giving, and receiving consent represent interrelated and ongoing processes, rather than discrete actions,[104] and consent is important for all youth, regardless of their background or individual identity. Meanwhile, individual characteristics (e.g., age and sex), situational influences (e.g., substance use), and relational contexts and histories (e.g., length of relationship, conflict avoidance) may be associated with giving, receiving, and seeking consent.

1. ***Giving consent*** involves communicating one's willingness to engage in sexual behavior. It also includes communicating that one does not want to engage in sexual behavior.[105]
2. ***Seeking consent*** involves inquiring about whether one agrees to sexual behavior or learning the person(s) does not, either through verbal or nonverbal signs.[106]
3. ***Receiving consent*** is the process through which an individual interprets whether they have received consent from another person and acted accordingly.[107,108]



Individual characteristics

Age

Young people ages 14-24 experience seeking, giving, and receiving consent differently than adults. Younger youth ages 14-18 report many barriers to saying "no," including trouble setting boundaries, low self-efficacy, impulse control that is still developing, and increased pressure from current or potential partners.[109,110] Further, youth in this age range are influenced by pressures from peers related to having sex or negative feelings about not having had sex.[111] Adolescence is a dynamic period for brain development, with processes that foster creativity and adaptability, but also challenges related to impulse control, emotional regulation, and decision making[112]—skills that are needed to assess risk when deciding whether to engage in sexual activity.

Sex

Young people generally use a combination of verbal and nonverbal consent.[113] Female young adults may be more likely to communicate and interpret consent using verbal cues compared to young males, who may be more likely to use and perceive nonverbal cues.[114,115] However, differences in how females and males communicate consent vary across situations and should not be overgeneralized to apply to all females and males and all situations.[116] Scholars discuss that these differences may be rooted in differences in social norms and societal expectations that influence different behaviors between females and males.[117] Talking with youth about these expectations and norms can help them understand differences in how their partners might approach consent and highlight the need to obtain clear consent before engaging in sexual activity.

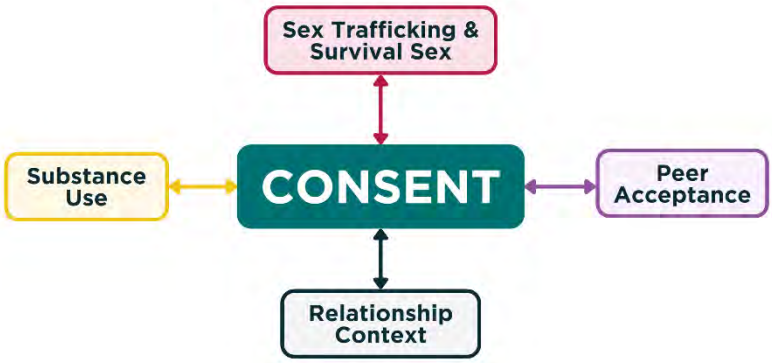
Disability

Many young people with intellectual disabilities are also sexually active and may express and perceive consent differently than young people without intellectual disabilities.[118] Furthermore, youth with disabilities experience higher rates of sexual violence than youth in the general population and may lack access to services when an assault occurs. [119]

Many factors contribute to the ability to consent among youth with disabilities, including knowledge of rights, access to sex education and services, and type of disability. Young people with intellectual disabilities generally have less understanding of their sexual rights and the difference between healthy, consenting relationships and abusive relationships, relative to their peers without intellectual disabilities.[120–121] The decreased understanding of sexual rights and healthy relationships is, in part, due to a lack of accessible sex education provided to individuals with intellectual disabilities.[122] Yet youth with intellectual disabilities do have bodily autonomy, and access to sexual and reproductive health education can help youth with disabilities understand consent and make informed decisions about whether to engage in sexual activity (or decline to engage).[123] Additionally, youth who are nonverbal and need other methods for providing consent may experience additional complexity during the consent process.[124]

Situational factors

Substance use



Substance use can influence one's ability to seek, give, and perceive consent because substances impact brain function and impulse control.[125,126] Research does not conclude that substance use rules out the ability to give consent, but it does find that being under the influence of substances can significantly alter or complicate cognition, feelings, communications, and perceptions related to consent.[127,128] There are instances in which one cannot provide consent due to substance use—for example, when one's speech is slurred or one is incapacitated, passed out, or unable to walk.[129] A study of young adults found that using alcohol (alone or in combination with cannabis) was associated with lower levels of internal consent, compared with sexual interactions that did not involve either substance.[130] In another study, young women reported using more verbal communication of consent when using alcohol than when they were sober.[131] Together, findings from these studies suggest that being under the influence of substances can impact a young person's feelings about consent and their methods for communicating consent in varying ways.

Some research has found that substance use may create misperceptions when giving, seeking, and receiving consent.[132] For example, studies find that, among young adults, accepting alcohol from a potential partner or drinking together may be perceived as nonverbal indicators of consent.[133,134] Researchers who interviewed 145 young adults ages 18 to 25 found that some participants reported relying on "intoxication parity" (i.e., perceiving that both parties were experiencing similar levels of intoxication) when deciding whether consent can be given during a sexual encounter under the influence of substances.[135]

Peer acceptance

Peer acceptance, or how young people are perceived by their peers, has been shown to be impacted by youths' engagement—or lack thereof—in sexual activity. For example, females who have sex report lower levels of peer acceptance, while males who have sex report higher levels.[136] Additionally, youth's perceptions of their peers' sexual behavior have been shown to be one predictor of their own sexual activity and behaviors.[137] Perception of their peers' sexual activity can impact youth's views of consent and the degree to which they feel pressured to engage in sexual activity.

Sex trafficking and survival sex

Youth involved in the child welfare system and/or those experiencing childhood maltreatment, youth experiencing homelessness, and those disconnected from work and school experience are at an increased risk for sex trafficking victimization[138] and engaging in survival sex.[139,140] Young people who experience homelessness may feel that survival sex is required to meet such basic needs as housing and food. Indeed, research demonstrates that the length and frequency of experiencing homelessness are related to increases in engaging in survival sex.[141] Youth and young adults experiencing sex trafficking or commercial sexual exploitation are also at increased risk of being involved with the juvenile or adult criminal legal systems because state laws largely prohibit sex work.[142,143]

Although the law generally prohibits sex work, young people who experience sex work may not realize they are being trafficked nor understand whether (or not) they are consenting to sex. A systematic review of 24 studies found that those who recruit youth into sex trafficking are most often identified as a partner (e.g., boyfriend/girlfriend) or friend.[144] Further, youth may not realize they are being trafficked, which can significantly impact their views of and experiences with seeking, giving, and receiving consent. Understanding consent within the context of sex trafficking and survival sex is critical for young people because engaging in commercial or transactional sex can place them at higher risk of PTSD and other mental health challenges,[145] as well as sexual assault victimization, negative health outcomes, and unmet needs for services (e.g., health care).[146]

Relational contexts

Different relational contexts and histories may influence consent, such as length of relationship, conflict avoidance among partners, and societal pressures. Studies about how young adults in long-term relationships communicate consent suggest that many people reduce explicit consent-seeking over time and instead rely on nonverbal cues and body language.[147,148] Although prior consent does not imply or provide consent for future sexual encounters, the type of consent one seeks and gives can change over time when there is sexual precedent between people.[149]

Additional relationship dynamics may also influence consent. For example, some young people report engaging in sex to avoid conflict or disagreement, or simply because they want to make their partner happy.[150] Young people may also feel that they owe someone sex or that their partner expects sex, or they may otherwise fear the social costs of withholding consent.[151] Trauma experiences can affect one's sexual self-efficacy, or the belief that they can navigate sexual activity, make choices to engage in sex, and communicate those decisions.[152] Together, these factors suggest that histories of trauma may impact a youth's ability to negotiate sexual situations with a partner (e.g., giving, seeking, and/or receiving consent).

Complexities and Caveats of Consent

Consent and the decision to engage in sexual activity sometimes must be about more than mutual sexual agreement. First, professionals who support youth, young people, and their partners should understand local law regarding statutory rape and the legal age of consent. Even in situations where there is mutual sexual agreement between youth, there can be legal ramifications to engaging in sexual activity. The legal age of consent varies by state, with some states considering only the age of each participant and other states considering additional factors such as the age gap between those involved.[153] Often, these issues are addressed in penal codes as to what constitutes various forms of sexual violence.[154] In some states—such as Texas,[155] Arizona,[156] and Pennsylvania[157]—there are exceptions to sexual activity laws when consensual sex occurs between individuals within close age proximity to one another, known as "Romeo and Juliet" laws.[158,159]

Further, definitions of legal consent vary across locales, institutions, and organizations.[160] Some laws, regulations, and policies at the state, local, or even institutional levels (e.g., an institution of higher education) may stipulate particularities regarding consent, such as requiring "affirmative consent" or "enthusiastic consent."[161] Failure to follow such policies can have different ramifications. When youth-supporting professionals are aware of regulations (and exceptions) in their jurisdictions that are applicable to the youth they support, they can help youth understand the complexities involved in decisions about various sexual activities. The Age of Consent website (https://www.ageofconsent.net/states) provides information about different laws and regulations pertaining to consent, such as the legal age to provide consent and when something is considered statutory rape. For youth-supporting professionals who are mandated reporters, it is important to know when criminalized sexual activity is reportable as child abuse and when it is not and to help the youth they support understand these implications.

Gaps in Existing Research

Throughout our literature search, we identified several gaps in existing research and practice literature. First, much of the literature focuses on samples drawn from college or university settings. Starting developmentally appropriate conversations about sexual activity early and as children age can lead to positive outcomes for youth.[162] Therefore, incorporating conversations and education about consent prior to college might be positive for youth and should be examined in future research. Furthermore, focusing on college populations may exclude many subgroups of young people such as those experiencing the child welfare and/or juvenile justice systems, homelessness, or disconnection from work and school. Much research also focuses on largely White youth samples, although research with young people across various racial and ethnic groups is becoming more common.[163] Lastly, based on our review, there is limited evaluation evidence focused on strategies to improve consent-related outcomes, including increasing young people's awareness of consent and their role in declining to engage in sexual activity.

Conclusion

Research describes multiple forms of consent, including external, internal, and legal consent. The definitions vary, as do the nuances that must be considered when understanding how the various forms of consent are communicated. Research also shows that individuals who have experienced trauma may seek, give, and receive consent differently than those who have not experienced trauma. For example, youth who experience trauma may be less assertive in providing consent and/or declining to consent. The ways youth seek, give, and receive consent are influenced by individual factors, such as self-efficacy; situational factors, such as substance abuse; and relational factors, such as the length of relationships and power dynamics within a relationship. Given the complex, multi-layered nature of giving consent or declining to consent, professionals can use this summary to strengthen support for youth through deeper knowledge about trauma- and evidence-informed information about consent.

Appendices

Appendix A. Sex education curricula

Below is a list of sex education curricula designed for youth experiencing the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work. The table provides details on whether consent and communication skills are included components of each curriculum.

Program	Consent is a component	Communication skills are a component	Outcomes
Power Through Choices	N	Y	Preventing teen pregnancy, HIV, and STIs, and improving ability to communicate with partner
Project Image	N	Y	Preventing pregnancy and STIs
Support to Reunite, Involve, and Value Each Other (STRIVE)	N	Y	Reducing risky sexual behavior, substance use, and delinquency
Sexual Health and Adolescent Risk Prevention (SHARP)-	N	N	STI/HIV prevention, condom use, sexual risks, and alcohol risk
Making Proud Choices! And Be Proud	N	Y	Sexual health knowledge, condom use, STI use
Healthy U	N	Y	Condom use, health-protective attitudes toward sexual health, and increased use of condoms/birth control
Thrive	Y	Y	Pregnancy prevention, sexual and reproductive health
Teen Talk Foster Youth	Y	Y	Does not specify outcomes

Appendix B: Methods

The authors used a multi-step process to narrow the topic, collect and curate the research and resources available, and obtain stakeholder input. A needs assessment that surveyed youth-supporting professionals across the country to identify gaps in resources identified the broad topic of sexual consent. Two topics related to consent emerged: 1) consent for sexual activity and 2) confidentiality with medical providers and understanding what information is kept confidential and what information must be reported (e.g., abuse). We then followed a five-step process described below.

1. First, we conducted focus groups with youth-supporting professionals, program administrators, researchers, and youth. From these conversations, we decided to focus on consent for sexual activity.
2. Next, we conducted a literature search using EBSCO and Google Scholar (first 3 pages of results) of peer-reviewed and grey literature and of resources about consent.
    a. We developed the following key terms: foster youth or young adults, youth or young adults in foster care, child welfare, homeless youth or young adults, unhoused youth or young adults, opportunity youth or disconnected youth, disconnected from work and school, and justice involved youth or young adults.
    b. We then searched each of those terms in combination with the following: sexual consent education, consent for sexual activity, consent education, consent communication, sexual consent, teaching consent, and comprehensive sex*ed*[d]. We extracted publications that were available in English, focusing mostly on U.S.-based samples and published from 2015-2024.
        i. We reviewed the abstracts and titles of each article and screened out articles that were not directly related to consent, resulting in screening out 1,301 articles.
        ii. We included 124 articles.
3. We used the results of the initial literature review to create an outline of consent-related topics and sought feedback from the Activate Research Alliance comprised of youth with lived experience, youth-supporting professionals, program administrators, researchers, and policymakers. The results of these discussions informed our decision to develop a research synthesis about the definitions of consent, types of consent, and influences of consent.
4. We needed to add literature to fill gaps in our synthesis. Supplemental literature and resource reviews included international studies.
5. We presented the research synthesis to the Activate Research Alliance for feedback. Once this feedback was received, we made multiple rounds of edits to address feedback. This included additional reviews to ensure we captured the feedback correctly.

[d] The asterisk denotes a search for any variation of "ed," such as education or educating.

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About the Authors

Rachel Rosenberg is a Senior Research Scientist at Child Trends.

Matthew Rivas-Koehl is a Research Scientist at Child Trends.

Brittany Mihalec-Adkins is a Research Scientist at Child Trends.

Colleen Schlecht is a Senior Researcher at Chapin Hall.

Jenita Parekh is a senior advisor at Child Trends.

Dane Rivas-Koehl is a consultant with Activate.

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A Practice Guide for Understanding Consent

Rachel Rosenberg, Matthew Rivas-Koehl, Brittany Mihalec-Adkins, Colleen Schlecht, Jenita Parekh, and Dane Rivas-Koehl

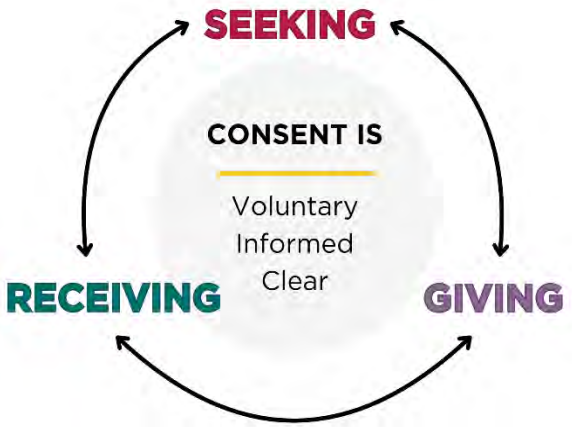
Introduction

This guide introduces the concept of consent for sexual activity and provides an overview of what youth-supporting professionals need to know about the topic of consent to inform their work with youth. The guidance is designed for youth-supporting professionals working with young people who experience the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from work and school. Research indicates that young people with these experiences have higher rates of trauma than their peers in the general population, which can affect how consent for sexual activity is understood and communicated.[a] Therefore, the information in this guide draws on trauma-informed research and guidance to ensure clarity and compassion in youth-supporting professionals' interactions with young people.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Consent for sexual activity (hereafter consent) is defined as a voluntary, informed agreement to engage in sexual activity conveyed through clear words or actions by individuals who are fully able to make this decision.[1,2] Since we define consent as the agreement for sexual activity, we also note the equally important decision to decline to engage in sexual activity throughout this guide. Consent is an active, ongoing process that includes the freedom to agree and the right to decline.[3] This process has three interconnected processes:

- **Giving consent**—communicating one's willingness to engage in sexual behavior. This process also includes communicating that one does not want to engage in sexual behavior.[4]
- **Seeking consent**—inquiring about whether one agrees to sexual behavior or learning the partner(s) does not agree through verbal or nonverbal signs.[5]
- **Receiving consent**—the process through which an individual interprets whether they have received consent from another person and acts accordingly.[6,7]



Consent can take different forms, including external and internal consent. External consent is clear communication about agreement to engage in sexual activity.[8] Internal

[a] For more information on how trauma is associated with consent, please see the accompanying research synthesis.

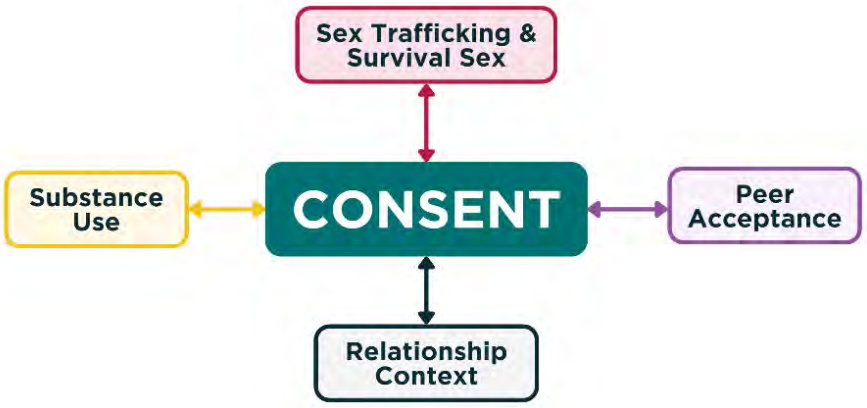
consent refers to how one feels about their affirmative decision to engage in sexual activity.[9,10] Both forms of consent are important and inform how a young person might feel about, think about, and communicate consent. Discussing the importance of internal and external consent should not be misconstrued as evidence of the myth that if a young person says "no," they mean "yes". Consent-related messaging focused only on external consent may overlook that not all young people feel safe or feel able to say "no" in all situations. For example, someone might say "yes" to an activity with which they do not feel comfortable but are afraid of negative repercussions if they say "no." Additionally, young people must respect the consent they receive. Further, if a potential partner hesitates or a young person is unsure if they received consent, they must pause, clarify if consent was provided, and stop if needed.[11]

Legal definitions mostly focus on external consent and vary by state. These definitions usually include factors such as age, intoxication (voluntarily and involuntarily), and consciousness. Youth-supporting professionals need to understand how consent is legally defined in the state where they work, including the state's mandatory reporting laws, specifically regarding young people's disclosure of sexual activity that may involve sexual assault or exploitation. For more information on states' mandated reporting requirements, see the following two resources: The National Center for Youth Law summarizes key information on age of majority and access to reproductive services, and this federal report provides a breakdown of different components of mandated reporting by state.

What do youth-serving professionals need to know about consent?

Youth-supporting professionals can help young people understand consent in developmentally- and age-appropriate ways,[12] regardless of a young person's experience with sexual activity.[13] Further, youth-supporting professionals can use this information to enhance their awareness about different influences on consent and inform their work to support young people. Youth-supporting professionals must remember that while understanding more about consent can help young people make informed decisions about engaging in sexual activity, consent education alone is not enough to prevent unwanted sexual activity.[14] Sexual violence prevention programs incorporate several other elements beyond consent to ensure that young people understand what sexual violence is, what resources are available to them if they have experienced sexual violence, and how to receive consent respectfully.[15]

The following table provides more information on the influences of consent—biological (e.g., age and sex), social (e.g., substance use), and other factors (e.g., relationship dynamics and survival sex).[16] Youth-supporting professionals can use this table to learn more about differences in how young people might approach giving, seeking, and receiving consent based on different factors. This information will not apply to all young people with these experiences but can provide a starting point for talking about consent with different groups of young people.



Influences on Consent

Influence	Influences on consent youth-supporting professionals should know:	Tips for sharing information with a young person about influences on consent:
Age	Young people ages 14-18 report barriers to declining to engage in sexual activity. They are still developing self-efficacy skills and may be more susceptible to peers influencing their views about sexual activity and consent.[17,18]	You may feel pressure to consent, but you should not say yes if you do not want to.
Sex	Some females may be more likely to give verbal consent, while some males may be more likely to use nonverbal cues to communicate their consent or decline to engage in sexual activity.[19,20,21] However, these differences may be due to societal expectations and norms.[22]	Some females are more likely to use words to communicate consent, and some males are more likely to use body language to communicate consent. However, this might be due to pressure people feel to act a certain way. You should always clearly ask for, give, and receive consent.
Substance Use	Substance use can influence youth's communication, behavior, and perception in ways that complicate giving, seeking, and perceiving consent.[23,24,25,26,27]	Being under the influence of drugs or alcohol can make it harder to communicate consent or refusal and can make it harder to understand what others are saying or feeling.
Relationship Dynamics	Young people might engage in sex to avoid conflict or make their partner(s) happy.[28] Young people may also feel they owe someone sex and fear the consequences of withholding sex.[29]	You may find it is difficult to say no to a partner if you are afraid you will upset them. You can always say no if you don't want to engage in sexual activity.
Survival Sex	Young people who engage in sex to meet basic needs[30] may have different experiences giving, seeking, and receiving consent. For example, a young person may feel like they have to say yes to sex to access housing,[31] which can change how they give and receive consent.	If someone is struggling to meet their basic needs like housing or food, they may feel pressured to agree to sex in exchange for money, food, or a place to sleep. If you find yourself in that situation, you do not need to say yes to having sex just to get the things you need. You can reach out to an adult (like me) who can help.

Communicating Consent

Verbal communication about consent reduces ambiguity and is the clearest way to communicate interest or disinterest.[32] You can remind youth that verbal cues can help avoid ambiguity or misinterpretations since youth often rely on nonverbal cues about consent.[33,34] The following table provides examples of verbal and nonverbal cues for communicating consent. This information can help youth-supporting professionals talk with young people about ways that consent is given, including examples of refusals to engage in sexual activity.

Ways Young People Might Communicate Consent

Type of Communication	Giving consent to engage in/continue sexual activity	Declining to engage in/continue sexual activity
	(Examples)*	***(Examples)****
Verbal Cues Only	**Providing direct, spoken communication agreeing to an activity[35,36]**	**Saying clearly and directly that you do *not* want to do something**
	Before: *"Yes, I'd love to do that!"[37]* **During:** *"I really like this! I'd love to keep going."[38]*	**Before:** *"No, I'd rather not do that."[39]* **During:** *"I'm not having fun anymore. I want to stop."[40]*
Nonverbal Cues Only	**Displaying actions and/or body language to show you're comfortable, interested, and/or in agreement with the activity[41]**	**Displaying actions and/or body language to show you're uncomfortable, not interested, and/or not okay with the activity**
	Before: *Excitedly nodding when someone suggests an activity in which you'd like to engage.[42]* **During:** *Taking a step closer or holding someone tighter during an interaction such as a hug.[43]*	**Before:** *Frowning and shaking your head or moving away when someone suggests an activity in which you do not want to engage.* **During:** *Pulling away from an interaction or pushing someone's arms or hands away.[44]*
Verbal *and* Nonverbal Cues	**Using words and body language to show agreement**	**Using words and body language to show refusal**
	Before: *"Yeah, a hug sounds nice," while opening your arms.[45]* **During:** *"This is nice," while leaning into the person you are hugging.[46]*	**Before:** *"No, I don't want a hug," while stepping away.[47]* **During:** *"Please let go," while pulling away from a hug.[48]*

*The examples provided in this table are informed by the research studies included in the accompanying research synthesis.

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Sexual Cyberbullying Research Summary

Colleen Schlecht, Amanda M. Griffin and Rachel Rosenberg

Purpose

Sexual cyberbullying is any sexually aggressive or coercive behavior facilitated by electronic media. Professionals who support youth experiencing the child welfare and/or juvenile justice system, homelessness, and/or disconnection from school and work (i.e., opportunity youth) identified a need for research-based information and resources to support their work with young people who may experience sexual cyberbullying. Sexual cyberbullying may have a detrimental effect on youth who have prior experiences with trauma,[1-3] unstable living arrangements,[4] and/or a lack of supportive adults in their lives.[5,6] Furthermore, some of these youth may rely on digital platforms to stay connected with family and friends from whom they have been separated, increasing their risk for being victims of sexual cyberbullying.[a,7,8]

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

This research summary:

1. Defines various forms of sexual cyberbullying
2. Reports what we know about the prevalence of these online behaviors
3. Discusses the factors that increase the risk for or protect youth against sexual cyberbullying as well as the potential consequences of experiencing sexual cyberbullying
4. Reviews what is known about preventing sexual cyberbullying
5. Shares information about relevant laws and resources for youth-supporting professionals who want to help youth who may experience sexual cyberbullying[b]

Overview and Implications

- **Definitions of sexual cyberbullying are inconsistent.** Youth-supporting professionals should be aware of the inconsistent definitions of sexual cyberbullying and the different forms that sexual cyberbullying can take.[9]
- **The risk for and prevalence of sexual cyberbullying varies by gender identity, sexual orientation, and age.**[10-12] Youth-supporting professionals should keep gender, sexual orientation, and age-related differences in sexual cyberbullying in mind when working with young people with diverse characteristics and experiences.
- **Sexual cyberbullying involving minors is illegal in all jurisdictions; however, laws are inconsistent across jurisdictions.**[13] Youth-supporting professionals who want to help youth who have experienced or been accused of sexual cyberbullying should familiarize themselves with the laws in their state.

[a] Sexual cyberbullying research does not, in general, focus on these youth. Therefore, this brief includes research about sexual cyberbullying among the overall population of adolescents as well as research on sexual cyberbullying specifically among youth who have experienced the child welfare and/or justice system, homelessness, and/or disconnection from school and work.
[b] The 2023 Activate Needs Assessment, discussions with Research Alliance members, and multiple literature scans led to the decision to focus this review on sexual cyberbullying.

- **Few sexual cyberbullying prevention programs are evidence-based.**[14] Because there are few prevention programs and/or curricula focused on sexual cyberbullying, youth-supporting professionals may need to rely on programs focused on cyberbullying broadly, in-person sexual harassment, or in-person stalking for information related to sexual cyberbullying. Evaluations of these types of prevention programs suggest that skill and knowledge-building components should be used to reduce sexual aggression.[15,16]

Definitions

Here we define several of the terms found in the literature on sexual cyberbullying that are used in this research summary. In current research, practice, and public discourse, these terms are sometimes used interchangeably, and the distinctions between them are not always clear.[17] Notably, the characteristics and dynamics of bullying, harassment, stalking, and dating abuse are similar regardless of whether they are perpetrated in person or facilitated by technology.

Sexual cyberbullying is an umbrella term for sexually aggressive or coercive behavior facilitated by using technology to intentionally harm, embarrass, threaten, or intimidate another person.[c] Technology can include e-mail, instant messaging, social media, chat rooms, websites, blogs, text messaging, or videos or pictures posted on websites or sent electronically.

Online sexual harassment refers to unwanted sexual conduct on any digital platform. This includes non-consensual sharing of images, pressure to send sexual images (sextortion), threatening to publish sexual content, and inciting others to commit sexual violence.[18]

Sexting involves "sending sexually explicit (or sexually suggestive) text messages and photos, usually by cell phone."[19] Sexting becomes sexual cyberbullying when it is nonconsensual/unwanted.

Sextortion involves forcing people to send sexually suggestive images which are then used to blackmail the sender with the threat of public exposure.[20]

The field of **cyberbullying is evolving**, and terms are used interchangeably in the literature and by researchers, youth-supporting professionals, and young people themselves. While colloquial or slang terms may be used in everyday life, our priority is to focus on the behaviors underlying the terms.

[c] The term "cyber" may be outdated and not relevant to youth. However, we are using it here because it is still used in the literature. Youth-supporting professionals should consider using other terms such as online or electronic or just asking youth how they refer to cyberbullying.

Cyberstalking involves using technology to repeatedly threaten, harass, and intimidate another person, making them concerned about their safety.[21]

Cyberdating abuse involves using technology to direct aggression against or control an intimate partner. The abuse can include sextortion, non-consensual sexting, online sexual harassment, or cyberstalking.[22]

Prevalence of Cyberbullying

This section of the research summary focuses on what we know about the prevalence of cyberbullying in general and certain forms of sexual cyberbullying (sexting and cyberdating abuse). Unless otherwise specified, the prevalence rates are based on general population samples of U.S. teens. Hence, they may underestimate the prevalence of cyberbullying among populations likely to be at elevated risk such as youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work.

Older female youth (ages 15-17) are more likely to experience **sexual cyberbullying** than younger female youth (ages 13-14) or male youth (ages 13-17).[12]

Cyberbullying: *Using technology to intentionally intimidate, threaten, or harm another*

Prevalence estimates of general cyberbullying vary due in part to differences in how the behavior has been defined and measured. A 2022 Pew Research Center study asked teens about different forms of cyberbullying using a definition of cyberbullying similar to the definition of cyberbullying we use in this brief. That study found that 46 percent of U.S. teens ages 13 to 17 reported ever experiencing at least one of the following cyberbullying behaviors: offensive name calling; being the subject of false rumors; receiving explicit images they did not ask for; having explicit images of them shared without their consent; physical threats; and/or persistent questioning about where they are, what they are doing, or who they are with by someone other than a parent.[23]

Sexting: *Consensual and nonconsensual texting sexually explicit messages or photos*

Sexting prevalence estimates vary depending on the age of young people, when the data were collected, the type of device being used, and whether the sext was consensual.[24] For example, there has been an increase in the prevalence of sexting over time and estimates of sexting prevalence are higher when a mobile device is used.[24] In one study, 20 percent of nearly 1,300 middle school students reported receiving a sext, and 5 percent reported sending a sext.[25] Sexting may be more prevalent among certain subpopulations of youth. In another study, 30 percent of first-time juvenile offenders reported having sent, received, and/or forwarded a sexually suggestive text message or nude or semi-nude picture or video in the past year.[26]

Some studies have looked specifically at nonconsensual sharing of sexual images or messages.

- A meta-analysis of 39 studies examining the prevalence of multiple forms of sexting behavior among youth under 18 identified five studies that measured forwarding a sext without the sender's consent. Across those five studies, the prevalence of forwarding a sext without consent was 12 percent of youth.[27]
- In one study, 25 percent of teen girls and 33 percent of teen boys (13 to 19 years old) reported receiving a sexual image without the original sender's consent.[28]
- In another study, 17 percent of 13- to 17-year-olds reported being sent explicit images they did not ask for, and 7 percent reported having explicit images of themselves shared without their consent.[29]
- That same study found that older teens (15 to 17 years old) are twice as likely as younger teens (13 and 14 years old) to report being sent explicit images they did not ask for (22% vs. 11%) and having explicit images of themselves shared without their consent (8% vs. 4%).[30]

Cyberdating abuse: *Using technology to control or direct aggression toward an intimate partner*

28% of middle and high school students in a relationship in the past year report being a **victim of dating abuse.**[21]

Cyberdating abuse is about as common among middle school students who are in relationships as among high school students who are in relationships, with roughly one in four students in relationships reporting being the victim of digital dating abuse (e.g., physical, sexual, or psychological/emotional violence that occurs between romantic partners using texting or social media). One form of cyberdating abuse is routinely checking on a partner's whereabouts. In one study, older teens (15 to 17 years old) were more likely than younger teens (13 and 14 years old) to report being persistently questioned online about their location and activities (17% vs. 12%).[32]

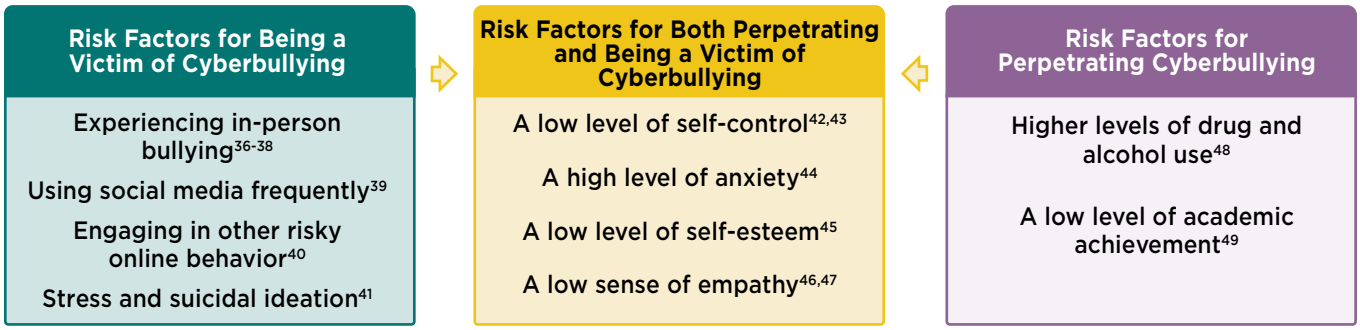
Risk and Protective Factors

Identifying risk and protective factors specific to sexual cyberbullying is challenging because research on sexual cyberbullying is limited and often fails to distinguish between (1) sexual cyberbullying and cyberbullying that is nonsexual in nature or (2) behaviors that occur in-person and those that occur online. Consequently, this section provides an overview of factors that increase young people's risk for or protect them against cyberbullying in general (Figure 1) and specific forms of sexual cyberbullying.

Furthermore, little sexual cyberbullying research has focused on youth who have experienced the child welfare and/or juvenile justice system, homelessness, and/or disconnection from school and work. However, given their increased risk for in-person sexual violence,[33-35] these youth may also be at increased risk for sexual cyberbullying. Therefore, youth-supporting professionals should be aware of the risk factors for sexual cyberbullying and in-person sexual violence.

When thinking about these risk and protective factors, it is important to consider other things that might be happening in young people's lives, such as unstable living situations or unhealthy relationships that might play a contributing role, putting them at risk for cyberbullying.

Figure 1. Risk factors for being a victim of and perpetrating cyberbullying



Cyberstalking and cyberdating abuse are two forms of sexual cyberbullying; girls are more likely than boys to be the victims of both.[50] Youth-supporting professionals should be particularly attentive to supporting girls and young women who have experienced this type of violence. Youth-supporting professionals should consider the societal factors, such as gender-based violence, that contribute to girls and women being more at risk and be sure not to blame them or insinuate they did anything to elicit the behavior. Risk factors for being a *victim of cyberstalking* include using multiple social media accounts and engaging in other risky online behavior such as socializing with strangers.[51,52] Risk factors for being a *victim of cyberdating abuse* include having a jealous romantic partner and engaging in sexting.[53,54]

In-person sexual violence and sexual cyberbullying are distinct experiences but youth who experience one may also experience the other, as has been found to be the case with traditional bullying and cyberbullying.[55] Moreover, although in-person and cyberstalking victimization are related, the relationship may be different for women than for men.[56] For example, females who are cyberstalked **first** are less likely to be **subsequently** stalked in-person, but males who are cyberstalked **first** are more like to be **subsequently** stalked in-person. Lastly, females who are stalked in-person are more likely to be stalked online as well.[57]

Community, family, and individual protective factors may buffer youth against cyberbullying broadly. Furthermore, many of the factors that protect against cyberbullying broadly, such as parental monitoring and peer support, also protect against non-consensual sexting, a form of sexual cyberbullying.[58] However, there is limited research on protective factors for specific forms of sexual cyberbullying beyond sexting.

Factors that protect against being a victim of cyberbullying include a positive and safe school climate,[59,60] positive parental interactions and higher levels of parental monitoring,[61,62] and higher levels of peer support and sense of "fitting in."[63,64]

Prevention

Prevention strategies for youth-supporting professionals

The broader literature on preventing bullying and sexual violence has three implications for successful sexual cyberbullying prevention:

- Online child sexual violence is perpetrated by strangers (65%) and acquaintances (39%).[65] Hence, youth-supporting professionals should talk with youth about ways to recognize cyberbullying involving sexual behaviors, and identifying adults they can go to for help.
- Preventing sexual cyberbullying requires an integrated approach. Youth-supporting professionals need to understand the ways different aspects of sexual cyberbullying and cyber and in-person sexual violence can occur in a young person's life.[66] For example, nonconsensual sexting can occur in the context of abusive dating relationships.[67]

- Sexual cyberbullying is most likely to occur during adolescence when young people begin dating and become involved in their first romantic relationships.[68] Adolescent bullying perpetration predicts subsequent sexual victimization and dating abuse in adolescence and even adulthood.[69] Thus, adolescent and early adulthood sexual cyberbullying prevention programs could be critical to preventing interpersonal and sexual violence later in life.[70,71]

Prevention program components

Service providers can draw information from effective prevention programs that target bullying, child sexual violence, and dating violence to begin considering program components essential for preventing sexual cyberbullying. For example, systematic reviews have found that in-person bullying, sexual violence, and dating violence prevention programs that incorporate the following components can reduce in-person bullying, cyberbullying, and cyberdating violence:[72]

- Peer engagement and role-playing[73]
- Problem-solving skills[74]
- Assertiveness, self-efficacy, and resistance to peer pressure[75]
- Empathy, perspective-taking, and difference appreciation[76]
- Training to identify "trusted helpers" and overcome barriers to help-seeking[77]
- Parent/caretaker involvement[78,79]

Another core component of effective programs that target cyber violence against children and dating violence is providing young people with knowledge relevant to bullying and sexual violence. Knowledge may include (1) being able to identify warning signs of cyberbullying; (2) understanding norms of healthy relationships; (3) knowing their rights and responsibilities; and (4) laws pertaining to sexual cyberbullying.[80-82]

Comprehensive sexual education programs for young people can also reduce physical and sexual aggression in particular, homophobic bullying and dating and partner violence.[83-85] Comprehensive sexual education programs guide students in identity development, healthy self-esteem, and body confidence. These concepts significantly influence one's sense of self, thereby decreasing the risk of students engaging in bullying or becoming victims of bullying.[86] Finally, programs effective at preventing cyberbullying teach young people about the effects of drugs because intoxication can reduce inhibitions. A review found substance abuse education is one of the most reliable components of successful in-person and cyberbullying prevention programs.[87]

Evaluations of prevention programs have typically involved high-income or school-based samples and thus may not apply to all populations.[88] However, a recent meta-analysis of studies that focus on young people at increased risk of domestic violence perpetration found that dating violence prevention programs can similarly reduce physical and sexual violence perpetration and physical domestic violence victimization.[89] It is unclear if evaluated programs are equally effective for youth who have experienced the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work.

Laws on Sexual Cyberbullying

The legal landscape around sexual cyberbullying is complicated and evolving quickly. At the time of publication, we are unaware of any *federal* statutes that criminalize cyberbullying,[90] but all states have various laws that apply to bullying behaviors, and the laws in all but two states include provisions related to "cyberbullying" or "online harassment."[91]

Legislating what individuals are allowed to do with sexual images or content online is challenging because sharing sexual images and discussing sexual activities online are not inherently illegal. When legislating the sharing of sexual images, states must consider the age of the sender, the intentions of the sender, and the relationship between the sender and recipient.[92] Additionally, legislation to protect victims of online sexual violence varies widely across states. This brief does not place value nor assess the effectiveness of any legislation intended to regulate any cyberbullying behavior. Rather, it encourages youth-supporting professionals and youth to be aware of the laws and understand that those behaviors can be illegal and carry potentially serious consequences.

- Sexting is generally legal unless it involves sexual harassment and/or a minor.[93] Sexting is not covered by any federal laws, but as of 2022, 27 states[d] had "sexting" laws.[94]
- Disseminating sexual photos is not illegal unless it involves a minor or occurs without the sender's consent.[95] As of 2022, 47 states had laws against "image-based sexual abuse," which involves sending explicit images without consent to cause emotional harm to the original sender.[e,91] In some states, this is a misdemeanor; in other states, it is a felony.[96]
- Forty-seven states[f] have laws to address "electronic" or "digital" stalking, but only six use the term cyberstalking in their statutes.[97]

The Cyberbullying Research Center provides state-specific information about cyberbullying, cyberstalking, sexting, and image-based sexual abuse laws. Youth-supporting professionals should review this resource to prepare for conversations with young people about sexual cyberbullying and familiarize themselves with (1) the age of consent for online behaviors, (2) definitions of sexual cyberbullying, online harassment, and stalking, and (3) criminal nonconsensual pornography laws.

Summary and Resources

The information in this research brief is designed to help youth-supporting professionals familiarize themselves with research about sexual cyberbullying to better support youth, especially youth who may be more vulnerable to sexual cyberbullying such as youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. To supplement the research, Table 1 provides resources related to sexual cyberbullying that youth-supporting professionals can use to support youth. Table 1 includes state and national resources that are youth specific, such as hotlines, and that can be useful to youth-supporting professionals.

[d] States with sexting laws: AZ, AR, CO, CT, FL, GA, HA, IL, IN, KS, LA, NE, NV, NJ, NM, NY, ND, OK, PA, RI, SD, TN, TX, UT, VT, WA, WV
[e] States without revenge porn laws: ID, MA, SC
[f] States without cyberstalking laws: MO, NE, NY

Table 1. Sexual cyberbullying resources

Organization and Contact Information	Mission
The Cyberbullying Research Center https://cyberbullying.org	Provides current information, resources, research, and technical assistance about the nature, extent, causes, and consequences of cyberbullying among adolescents. The resource is intended for parents, educators, law enforcement personnel, and all youth-supporting professionals. There are also specific resources for LGBTQ+ youth.
Trevor Project www.thetrevorproject.org 866-488-7386 Text START to 678-678	A 24/7/365 national hotline that provides crisis services, advocacy, peer support, public education, and research programs helping to ensure that all LGBTQ young people have supportive adults in their lives.
Without My Consent https://withoutmyconsent.org/resources/	A project under the Cyber Civil Rights Initiative protecting online privacy. Resources focus on supporting individuals who experience incidents of nonconsensual distribution of sexually explicit images. For example, there are criminal and civil solutions state by state.
Cyber Civil Rights Initiative 844-878-CCRI www.cybercivilrights.org	A national hotline that provides support for nonconsensual pornography and online abuse with 24-hour hotline and one-on-one support for victims. Provides resources for lawmakers to draft legislation, educational resources, and a list of states with "revenge porn" laws with references to the applicable criminal statutes.
California Department of Justice Cyber-exploitation https://oag.ca.gov/cyberexploitation	Provides support during incidents of the nonconsensual sharing of intimate media with resources for victims for image removal, tools for law enforcement, and best practices.
Crisis Text Line Text HOME to 741-741 https://www.crisistextline.org/	A national hotline that provides free and confidential text-based mental health support and crisis intervention.
National Domestic Violence Hotline 1-800-799-7233 www.thehotline.org	Provides community referrals for resources related to intimate partner violence, including teen dating violence.
Love is Respect 1-866-331-9474 Text: loveis to 22522 www.loveisrespect.org	A national hotline that is operated by the National Domestic Violence Hotline but tailored toward providing teens information about healthy relationships and resources for parents and educators.

Organization and Contact Information	Mission
Rape, Abuse & Incest National Network www.rainn.org 1-800-656-HOPE	A national hotline that responds to a wide range of sexual victimizations with referrals to local sexual assault services programs. Provides links to opportunities for volunteering and activism.
National Center for Victims: Stalking Resource Center https://www.stalkingawareness.org	Provides resources to educate professionals on how to keep stalking victims safe and hold offenders accountable. These are not resources for victims/survivors of stalking.
Online Harassment Field Manual https://onlineharassmentfieldmanual.pen.org/federal-laws-online-harassment/	Summarizes how to report federal crimes; key federal laws that may apply to online abuse; and how federal copyright law may be relevant for pursuing legal action against online abuse in civil court.
MaleSurvivor www.malesurvivor.org	Provides therapists, support groups, and other resources for male survivors of sexual abuse.
National Center for Missing & Exploited Children 1-800-843-5678 http://www.missingkids.com/cybertipline/	A national hotline for reporting child sexual exploitation, online solicitation of sexual images, and sextortion. National method of reviewing cases for law enforcement agencies.
StopCyberbullying.gov https://www.stopbullying.gov/cyberbullying/what-is-it	Provides an overview of what cyberbullying is, laws and sanctions of cyberbullying, and prevalence of cyberbullying. There are also specific resources for LGBTQ+ youth.
National Center for Youth Law: Commercial and Sexual Exploitation https://youthlaw.org/focus-areas/commercial-sexual-exploitation	Provides resources on human trafficking and sexual exploitation.
NetSmartz https://www.missingkids.org/netsmartz/home	Operates the CyberTipline where people can report suspicions of online and offline sexual exploitation of minors.

Appendix: Methods

Sexual violence emerged as a priority topic during the 2023 Activate Needs Assessment. After identifying a need, we conducted a high-level literature scan to identify topics related to sexual violence. We summarized our findings and then engaged Research Alliance members to define the scope of the review. First, we had conversations with Research Alliance members to review the needs assessment findings and to understand which topics were relevant to their work and priorities for a research summary and Activate resource. Second, we shared the findings from the research review and solicited feedback during a Research Alliance meeting discussion group. These activities highlighted important considerations for this resource, including:

- Research Alliance members reported that cyberbullying and cyberdating abuse were the most common forms of sexual violence experienced by the young people with whom they work.
- Research Alliance members reported that young people often do not have the language to label their experiences as cyberbullying or cyberdating abuse.
- Research Alliance members reported that young people struggle with how to communicate appropriately about their romantic interactions and relationships with peers and partners.
- Research Alliance members reported that youth-supporting professionals need more concrete supports and resources to help young people process their feelings when sexual cyberbullying occurs.
- Research Alliance members reported that youth-supporting professionals need more information about a variety of topics including the laws on online sexual behavior, youth rights related to online sexual behavior, talking with youth about these topics safely, responding when youth report being victimized by these behaviors, and preventing revictimization.

After identifying the need we then conducted a supplemental literature scan focused on various forms of sexual cyberbullying. We searched research databases (Academic Search Complete, LGBTQ+ Source, and OmniFile Full Text Select) as well as Google Scholar using terms like cyberbullying, trolling, doxing, cyberdating abuse, and cyberstalking with population terms specific to Activate's youth populations. Research articles needed to be published in English after 2013, and the research needed to be conducted using a sample from the United States. Ultimately, we exported 223 potentially relevant articles; we subsequently dropped 139 articles determined to be off-topic or based on data collected outside the United States. We identified an additional 103 articles by manually reviewing the articles and their reference lists. Altogether, our review included 156 articles.

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About the Authors

Colleen Schlecht, MPP, is a Senior Researcher at Chapin Hall at the University of Chicago.

Amanda M. Griffin, MS, PhD, is a Researcher at Chapin Hall at the University of Chicago.

Rachel Rosenberg, MSW, PhD, is a Senior Research Scientist at Child Trends.

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How to Decode Signs of Sexual Cyberbullying and Support Teens and Youth

Colleen Schlecht, Amanda M. Griffin, and Rachel Rosenberg

Child Trends®

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Introduction

How to Decode Signs of Sexual Cyberbullying and Support Teens and Youth explains how to identify, recognize, and support youth who may experience and/or engage in sexual cyberbullying.[a,b] This primer from Activate* is meant for professionals who support young people who experience the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Sexual cyberbullying is a broad term used to describe any sexually aggressive or coercive behavior facilitated by technology to intentionally harm, embarrass, threaten, or intimidate another person.[c] Youth can experience and/or engage in sexual cyberbullying.

Sexual cyberbullying is harmful to all youth, especially youth who have experienced trauma,[1,2] unstable living arrangements,[3] and/or a lack of supportive adults in their lives.[4,5] Furthermore, some youth may rely on digital platforms to stay connected with family and friends from whom they have been separated and experience an increased risk for sexual cyberbullying.[6–8]

** Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals* bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Decoding Sexual Cyberbullying Behaviors

What does sexual cyberbullying look like?

Sexual cyberbullying behaviors include:

The chart on the next page describes sexual cyberbullying behaviors and examples of each sexual cyberbullying behavior.

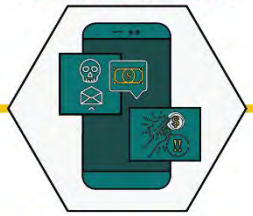
[a] The information provided in this resource is based on Activate's summary of research on sexual cyberbullying.
[b] We use "experience and/or engage in sexual cyberbullying" to refer to youth who experience sexual cyberbullying, engage in behaviors of sexual cyberbullying, or both. This language is purposeful and YSP should avoid labeling youth as victims or perpetrators in this work.
[c] The term "cyber" may be outdated and not relevant to youth. However, it is still used in the literature. Youth-supporting professionals should consider using other terms such as online or electronic or ask young people what words they would use.

Sexual Cyberbullying Behaviors

SEXTORTION

WHAT IS THIS BEHAVIOR?

Non-physical way of forcing sexual favors by threatening to reveal evidence of someone's sexual activity.[9]



WHAT COULD IT LOOK LIKE?

Receiving or sending a message claiming that an explicit image (e.g., a nude) will be shared online unless one complies with the sender's requests.[10]

ONLINE SEXUAL HARASSMENT

Unwanted sexual behavior on any digital platform.[11] This can occur between anyone, including family, friends, acquaintances, or strangers.

Receiving or sending an unsolicited message on Instagram asking about what someone likes/is into sexually.

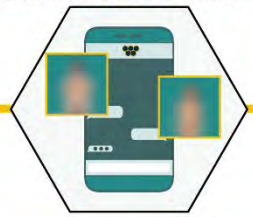
NONCONSENSUAL SEXTING

Nonconsensual texting of sexually explicit messages or photos.[12] This can occur between anyone, including family, friends, acquaintances, or strangers.

Receiving or sending a naked picture on Snapchat without consent.

REVENGE PORN

Revealing sexually explicit images or videos of a person on the internet without the consent of the subject to cause them distress or embarrassment.[13]



Distributing photographs or videos of an ex-partner, obtained via hacking or other methods. Finding an explicit image or video of oneself that an ex-partner posted without consent after a breakup.

CYBERSTALKING

Using technology to repeatedly threaten, harass, or intimidate another person, making the other person concerned about their safety.[14] This can occur between anyone.

Receiving/sending messages through a social media platform saying that one is being watched. This includes watching someone's social media to learn where they are and arriving uninvited.[15]

CYBERDATING ABUSE

Using technology to spread negative information (e.g., spreading rumors, talking badly about their body) or to direct aggression or control toward an intimate partner or romantic interest.[16]

Spreading rumors about a partner or romantic interest's sexual identitiy/orientation on an online gaming chat room. Or, finding hurtful comments about one's body on a partner's Instagram post.

Where does sexual cyberbullying happen?

Sexual cyberbullying can occur through:	Sexual cyberbullying can occur on:
• Email • Instant messaging • Text messaging • Public posts and direct messages	• Social media applications (apps) • Online dating apps • Online gaming forums (e.g., video game chat rooms) • Blogs • Other websites

Although online platforms allow young people to communicate, and to easily and directly connect with peers, they can also be used to search for people or post information anonymously. Professionals should be aware of social media and dating apps young people frequently use, as well as their logos. A 2024 Pew Research Center publication—*Teens and Social Media Fact Sheet*—provides more information about how teens use online platforms.[17] A recent literature review examined what is known about how sexual harassment is facilitated by dating apps.[18]

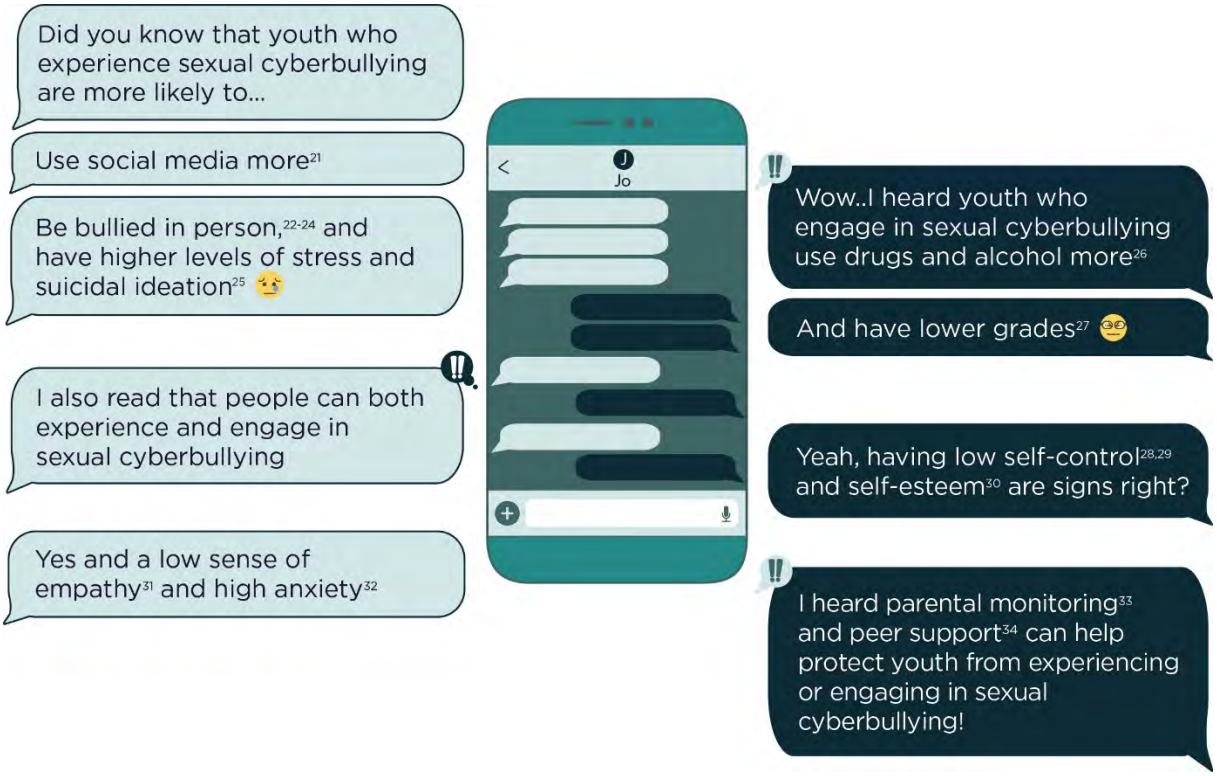
You can help youth protect themselves. Youth need to know how to use these settings for each app to protect their personal information and minimize their risk for experiencing sexual cyberbullying.[19,20] Every app has its own privacy and location settings.[d] For example, youth should know whether their posts on different apps are public or private, whether the app is tracking their location, and whether it sells their personal information to third parties.

[d] At the time of publication, Senate bill 1409: Kids Online Safety Act passed the U.S. Senate with bipartisan support and will move to the House of Representatives. The bill aims to hold tech companies such as Facebook accountable for harmful online behavior such as bullying and sexual cyberbullying. The bill requires tech companies to use a "duty of care" and default settings as the safest possible.

Decoding Signs of Sexual Cyberbullying

What are the signs of sexual cyberbullying?

Some factors may put young people at higher risk of experiencing and/or engaging in sexual cyberbullying behaviors, while others may protect young people against experiencing or engaging in those behaviors. Not all young people who exhibit risk factors will experience and/or engage in sexual cyberbullying. However, youth-supporting professionals should be aware of these factors and be prepared to talk about sexual cyberbullying with youth who exhibit them.



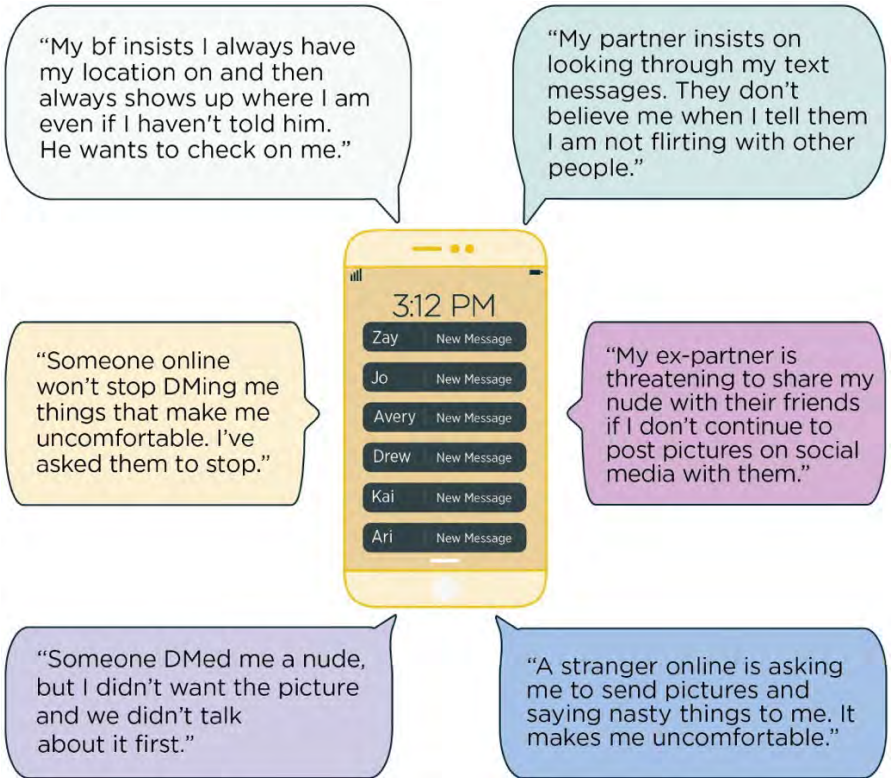
What signs of sexual cyberbullying can you listen for?

Understanding how young people describe sexual cyberbullying can help youth-supporting professionals identify when sexual cyberbullying is occurring.

In addition to slang, emojis may also have sexual connotations. Be aware that youth may talk through emojis, and the meaning of emojis change frequently. Talk with youth to determine whether they are experiencing sexual cyberbullying and/or sexually cyberbullying others.

The quotes in the graphic below are examples and include vernacular terms/slang that young people and youth-supporting professionals report commonly hearing. However, slang changes over time and varies by geography and culture, among other factors. The slang used in these examples may not match the slang you hear from youth.

A youth who is experiencing sexual cyberbullying may say:



A youth who is sexually cyberbullying others may say:

Decoding How to Help Youth

- **Teach young people** how to use privacy and location settings to protect their personal information and minimize their risk for experiencing sexual cyberbullying.
- **Educate young people** on how to use technology safely and protect themselves against malicious behavior online by teaching them the signs of sexual cyberbullying.
- **Learn about sexual cyberbullying laws** within your state. There is variation from state to state in what is considered sexual cyberbullying,[31] so make sure you know the laws within your state and have conversations with youth about those laws.
- **Have routine conversations with young people** to teach them about sexual cyberbullying, including what it looks like, why it is harmful, and whether to do anything/what to do if they are experiencing and/or engaging in sexual cyberbullying.
- **Discuss consent with young people** and ensure they know that photos of themselves or others should not be shared without permission.
- **Demonstrate support for young people** who have experienced sexual cyberbullying by asking them what they need.
- **Demonstrate support for youth who cyberbully others** by asking about their understanding of their behavior, explaining reasons why sexual cyberbullying is not acceptable, and connecting them to services to understand the root causes of their behavior, if needed.
- **Connect youth with local services** (e.g., counseling, digital safety courses, legal consultation) to support their mental health and legal needs after sexual cyberbullying occurs.

Prepare for conversations about sexual cyberbullying by reviewing these resources:	
Privacy Settings for Social Media Apps	A youth centered resource that shares links to privacy settings instructions for popular social media sites.
Project iGuardian	Program to keep teens and youth safe from online predators through education and awareness.
National Sexual Violence Resource Center	Center that provides information to prevent and respond to in-person and cyber sexual violence.
The Cyberbullying Research Center	Center that provides information to prevent, identify, and respond to instances of cyberbullying.
Cyberbullying Laws	Online tool that summarizes cyberbullying laws in each state.
What Is Consent?	Online resource to help people understand what consent looks like.
Without My Consent	Online resource that provides multiple tools to fight online harassment.
Let's Talk Consent	A flyer explaining consent with additional resources.

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Supportive Adult Connections, Teen Pregnancy, and Youth Mental Health

Samuel Beckwith, Brittany Mihalec-Adkins, Lee Ann Huang, Shaniah Smith, and Julia Tallant

Purpose

Mental health and teen pregnancy-related outcomes are both important to young people's overall well-being, and often intersect in ways that matter for research, policy, and practice. Examining these areas together, as related factors, can help identify critical protective factors—relationships, resources, or supports that promote positive outcomes for youth. For young people who experience homelessness, disconnection from school and work, or involvement with the child welfare or justice systems, connections with supportive adults are meaningful protective factors for well-being across multiple areas of their lives. For the youth-supporting professionals who work with these young people, the questions of how and why to be a supportive adult are highly relevant.

This research summary examines the intersections between mental health, teen pregnancy, and related sexual and reproductive health outcomes, describes how nonfamilial supportive adults are a well-documented protective factor across multiple areas of well-being for young people's mental health and sexual and reproductive health, and highlights additional ways youth-supporting professionals can support the well-being of young people. This resource provides an overview of recent research and is meant to complement Activate's tool, *A Practice Guide for Promoting Youth Mental Health and Sexual and Reproductive Health as a Supportive Adult*, which provides research-informed strategies for youth-supporting professionals to apply the findings discussed here.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

Overview

- Young people's mental health and sexual and reproductive health, including teen pregnancy, are connected in nuanced ways.
- Supportive adults may include youth-supporting professionals, formal mentors, and informal or "natural" mentors.
- Young people who are connected to supportive adults tend to have improved sexual and reproductive health and mental health outcomes, relative to young people who do not have supportive adults in their lives.
- Supportive adults can help young people navigate common challenges that can affect their well-being and help ensure that young people have access to basic resources and supports (such as health care) that are closely tied to health.

Intersections Between Mental Health and Teen Pregnancy

Mental health and mental illness are not the same thing. Mental health includes positive emotions and strengths like emotion management, coping with stress, and life satisfaction, as well as feelings of distress or mental health conditions such as a depressive or anxiety disorder.[1] Everyone has mental health, and it is one important component of overall well-being. Further, mental health and sexual and reproductive health (including outcomes like early and unintended pregnancy) are often correlated. This is true for young people as well as adults. The relationship between teen pregnancy and mental health is nuanced, and these two aspects of health can influence one another in a variety of ways.[2] Young people who have positive perceptions of their sexual and reproductive health, for example, are more likely to have good mental health.[3] At the same time, those who experience challenges with their mental health (e.g., depression, anxiety) have been found to have adverse sexual and reproductive health experiences (e.g., unintended pregnancy, delays in accessing contraception).[4] Likewise, adverse experiences like unintended pregnancies can trigger mental distress.[5,6]

Previous Activate research summaries have described why pregnancy prevention is particularly important for young people experiencing homelessness, the justice system, the child welfare system, or disconnection from school and work. Broadly, experiencing adversity early in life, such as maltreatment or family disruption, is associated with increased likelihood of teen pregnancy.[7,8] Similarly, adverse experiences like maltreatment or housing instability, for example, can also strain young people's mental well-being.[i,9,10,11,12]

Why sexual and reproductive health outcomes beyond teen pregnancy are considered in this research summary

Teen pregnancy is not an event that occurs in a vacuum. It is shaped by sexual health knowledge,[13] contraceptive and condom use,[14,15] how long youth have been sexually active,[16] access to clinical services,[17] pregnancy intentions and desires,[18,19] and other factors. For this reason, we consider a spectrum of sexual and reproductive health outcomes to gain a broader understanding of the protective influence of supportive adults.

Connections With Supportive Adults

Positive connections with other people—such as peers, family members, and supportive adults—can be critical protective factors for young people. This resource focuses on positive influences in the form of *supportive adults*, including connections with mentors, youth-supporting professionals, and other caring and trusted adults. Other types of interpersonal connections (e.g., peer, family) are not the focus of this resource, but are discussed in other Activate resources such as *Harnessing Positive Peer Influence to Reduce Substance Use and Unintended Teen Pregnancy* and *Exploring the Dual Experiences of Parenting While Being Parented*.

Relationships with supportive adults have often been studied in the context of mentoring relationships. Mentoring relationships may be formal, like those established as part of a structured mentoring program.

[i] Research on protective factors for young people in Activate's focal populations remains limited. This research summary draws from literature based on broader populations of youth but indicates when studies *have* included one or more of Activate's focal populations in the samples to describe population-specific findings.

Young people may also have "natural mentors"—non-parent adults who are a part of a young person's life (e.g., a coach, teacher, or religious leader) and who provide mentorship outside of a formal mentoring program.[20,21,22] Natural mentorships typically develop organically between a young person and a non-parental adult, rather than through formal structure.

In addition to mentorship, relationships with youth-supporting professionals in the context of a program or service can also be highly protective when the professional's approach is evidence-based and builds connection and knowledge.[23,24,25] Research has identified the importance of young people's connections with caring, non-judgmental, informed adult service providers.[26] Studies show that young people who experience systems such as child welfare or juvenile justice need supportive adults who provide reassurance, informed advice, and age-appropriate boundaries and expectations while also taking youth voice into account.[27] Young people seek connections with youth-supporting professionals who are attuned to their needs and are willing to engage in ongoing conversations.[28]

Given the important role of supportive adults, the following sections summarize existing evidence for supportive adults as protective factors for young people's sexual and reproductive health (including prevention of unintended teen pregnancy) and mental health.

Youth sexual and reproductive health

Research has repeatedly found supportive adult relationships to be a protective factor for a number of sexual and reproductive health outcomes during adolescence and young adulthood. Ojukwu and colleagues conducted a review of research on teen pregnancy, with a focus on studies that engaged mostly Black adolescents. The review found that across multiple studies, supportive neighborhood environments and experiencing mentorship from adults were associated with a decreased likelihood of experiencing pregnancy during adolescence.[29]

Supportive adult connections may be particularly important for young people with challenging circumstances, such as involvement with the child welfare or justice systems. Researchers have found that young people involved with the child welfare system or in foster care had a lower likelihood of having new sexual partners when their caregivers were knowledgeable about their lives, including their whereabouts and activities.[30] Supportive adults can help connect young people involved with the child welfare system with information about contraceptives and how to access them.[31] For young people experiencing homelessness, connections with natural mentors may increase the likelihood that they will use contraception and reduce the odds of engaging in risky sexual behaviors.[32]

Connections with supportive adults within their communities and schools are associated with young people being less likely to initiate sexual activity, having fewer sexual partners, and being less likely to be diagnosed with a sexually transmitted infection.[33,34] A systematic review of qualitative research on how school experiences affect young women's decisions about pregnancy and parenthood found that teachers were

notable influences: Students whose teachers set high expectations for educational attainment may be more likely to continue in school and, in turn, less likely to experience pregnancy as a teenager or young adult.[35]

Youth mental health

Research has consistently found that relationships between young people and safe, supportive adults are protective of mental health.[36,37,38,39] For young people who are already experiencing mental health challenges, adults who act as mentors can support their mental health by being a consistent presence who listens and "shows up."[40] Mentors are associated with lower depressive symptoms and social anxiety for young people.[41] Young people who have a natural mentor in their life experience higher levels of positive mental health outcomes than those who do not have a natural mentor, including positive social-emotional development and satisfaction with social support.[42,43,44]

Connections with adults that support mental health can also go beyond mentor-style relationships. For young people still in school, positive relationships with teachers and a higher sense of "connectedness" to school are associated with less loneliness, decreased emotional distress, and lower odds of suicidal ideation.[45,46] Analysis of data from nearly 15,000 middle- and high-school students in California found that students who had closer, more supportive teacher connections reported higher levels of mental well-being and slightly lower levels of depressive symptoms. The study also found that having supportive relationships with non-family adults in the community was similarly associated with better mental health.[47]

The benefits of being connected to supportive adults may be long-lasting. Bethell and colleagues analyzed survey data from adults and found that the odds of experiencing depression or poor mental health in adulthood were roughly 40 percent lower for those who had at least two non-parental adults who took a genuine interest in them when they were younger compared with those who did not have such supportive adult connections when they were younger.[48]

Ways Supportive Adults Can Protect Young People's Well-being

The above sections explore the links between supportive adults and youth mental health and sexual and reproductive health. There are a variety of ways that supportive adults can protect the sexual and reproductive health and mental health of young people, and the most important ways may be different for each young person, depending on their individual needs. The sections below describe two broad types of support that can be beneficial: helping young people navigate common challenges and risks, and helping young people access critical services, resources, and social connections that promote well-being.

Helping young people navigate challenges and risks

To date, much of the research about teen pregnancy and mental health in young people has focused on risk factors. Although this research summary focuses on supportive adult connections as a protective factor, youth-supporting professionals should be aware of common risk factors that can affect both sexual and reproductive health and mental health for youth. For instance, many adverse life experiences have been linked with negative outcomes related to both sexual and reproductive health and mental health in adolescence and emerging adulthood. In particular, childhood experiences of maltreatment (abuse and neglect) have been linked with lower levels of flourishing (defined as "perceived success in relationships, self-esteem, meaning, purpose, and optimism"), higher rates of teen pregnancy, and a number of other adverse mental health and sexual and reproductive health outcomes.[49,50,51,52] Other risk factors include being bullied or experiencing peer violence, which have been linked with loneliness;[53] depression, anxiety, and other mental health outcomes;[54] a higher number of recent sexual partners;[55] and earlier sexual

initiation.[56] Experiencing relationship-based violence also poses significant risks to young people's mental health, likelihood of teen pregnancy, and other sexual and reproductive health outcomes.[57,58,59]

Young people who experience the child welfare or juvenile justice system, homelessness, and disconnection from school and work may face higher-than-average odds of experiencing the challenges described above,[ii] which in turn can pose risks to their sexual and reproductive health and mental health. Importantly, youth-supporting professionals can help reduce the impacts of various risk factors and support young people's mental health and sexual and reproductive health. Research has found that when young people are connected to supportive adults, they are more likely to have access to other resiliency-promoting factors such as having supportive friends or access to community resources.[60]

Supportive adults have been found to diminish students' fears about being bullied in school and may help mitigate the relationship between bullying and suicide attempts.[61,62] Research has also found that young people are more likely to tell adults in their lives about bullying experiences if those adults have communicated an intolerance for bullying, suggesting that supportive adults can act in concrete ways that may make young people more likely to disclose their bullying experiences.[63]

Supportive adults can also be helpful in instances of relationship violence. Adolescents who have supportive adults who they feel comfortable talking with about relationship violence are more likely to be open to seeking help about intimate partner violence from others.[64] Steiner and colleagues found that school connectedness, which includes closeness with school staff, was associated with reduced likelihood of experiencing various forms of relationship violence in adulthood, indicating that supportive adult connections may have long-term protective benefits for youth.[65]

While adverse childhood experiences such as abuse or neglect are associated with a substantially elevated risk of depression in adulthood, Lee et al. found that having high levels of social support in childhood, which includes connections to trusted adults, cuts this risk increase roughly in half.[66] Similarly, having a higher degree of connectedness to school, including to school staff, may lessen the influence of early adversities on sexual and reproductive health outcomes – reducing the likelihood of outcomes including sexual initiation and teen pregnancy.[67]

[ii] For more information and practice-oriented guidance, please refer to Activate resources such as *Sexual cyberbullying research summary*, *Healthy romantic relationships and youth well-being*, *A research-based question and answer resource on intimate partner and teen dating violence for youth-supporting professionals*, and *Seven dimensions of access to sexual and reproductive health care for youth*.

Supporting the basic conditions for well-being

Supportive adults can help young people by connecting them to the basic services, resources, and social connections that support well-being, such as stable housing,[68] coordinated care,[69] and placement stability if in foster care.[70] Compared with their peers, young people who experience homelessness, the child welfare system, the justice system, or disconnection from school and work may experience more interruptions to stable housing, coordinated care, placement stability, and other supports that shape well-being.[71,72] As such, these young people may need additional support for their sexual and reproductive health and their mental health.

Importantly, youth-supporting professionals may advocate for young people to receive evidence-based services that can support both sexual and reproductive health and mental health. Existing research suggests that a range of supportive services and interventions can help promote positive sexual and reproductive health outcomes for young people. For instance, Multidimensional Treatment Foster Care placement has been associated with lower rates of pregnancy over time for youth in foster care, with researchers emphasizing the role of mentorship, guidance, and attention in supporting the well-being of teen mothers and their infants.[73] A systematic review of 23 studies focused on preventing rapid repeat pregnancy among adolescents in foster care also found that the most promising approaches were those that included a case management component, possibly suggesting benefits of relationships with youth-supporting professionals like caseworkers.[74]

Strategies to support basic conditions for young people's well-being:

- Provide holistic, evidence-based services to young parents in foster care that include mentorship, guidance, and attention to both young parents' and infant's well-being.
- Incorporate case management into services, and support case managers to build trusting, collaborative relationships with young people.
- Increase young people's access to relevant, evidence-based health care services, including mental health services.
- Ensure young people's fundamental needs, such as access to stable shelter and food, are met.
- Create space and opportunity for young people to build positive peer social connections.

Access to care is also critical for young people's sexual and reproductive health.[75,76] Offiong and colleagues describe different dimensions of access to sexual and reproductive health care in detail and offer a tool for assessing the landscape of sexual and reproductive health care providers in communities.[77] A systematic review of five studies on preventing rapid repeat pregnancies for broader groups of young people found that access to evidence-based health care services was protective, and promoted the use of contraception or family planning.[78] Other research has found that access to school-based sex education can have positive impacts on sexual and reproductive health behaviors, such as delaying sexual initiation and increasing condom use,[79] including for young people impacted by the juvenile justice or child welfare systems.[80] Supportive adults may also provide young people with encouragement to access health care, or even go with them to medical appointments.[81]

Regarding mental health, researchers have found success with school-based interventions to reduce self-harm and suicidal behaviors.[82] Researchers who reviewed 17 studies found mixed evidence for effectiveness of psychosocial interventions to boost mental health for pregnant and parenting adolescents, finding small but positive benefits for general mental health and school attendance,[83] which may be particularly relevant for youth-supporting professionals who work with young people who are disconnected from work and school. Overall, however, the researchers concluded that there is a critical need for more research in this area.[84] Other gaps in research include best practices for promoting mental health among youth incarcerated in detention facilities.[85] While limited, available evidence suggests that youth-supporting professionals who work with young people involved in the juvenile justice system should be

informed about mental health broadly and also promote collaboration between juvenile justice and mental health care systems.[86]

Finally, youth-supporting professionals may be able to support young people in developing or maintaining other social connections that may support their well-being (e.g., positive family members, peers, or community members). Hardy and colleagues, for example, studied the social support networks of youth experiencing homelessness. They found that those youth who were frequently in contact with their support network, and whose networks could provide high quality support, had greater resilience and felt more relief from engaging their networks for help.[87] Similarly, a study of young people experiencing homelessness who had a mental illness found having supportive social relationships and a sense of belonging in the community contributed to mental health recovery.[88]

Conclusion

Together, the research summarized here suggests that supportive adult connections can be an important protective factor for young people's mental health and sexual and reproductive health. Supportive adults can help young people feel connected, access needed services and resources, and navigate risks that may affect their well-being. For tips on how to be a supportive adult who helps young people build strengths and well-being in these important areas of health, refer to this practical guide: *A Practice Guide for Promoting Youth Mental Health and Sexual and Reproductive Health as a Supportive Adult.*

Methods

We developed this research summary using a multi-step, iterative literature search process, described below.

Step 1: Preliminary academic literature search

First, we conducted searches using PubMed and Google Scholar to identify research published since 2015 on 1) risk and protective factors for mental health and teen pregnancy and 2) studies that assessed both mental health and teen pregnancy. These searches prioritized review articles (e.g., systematic reviews, meta-analyses, conceptual models). An example search is as follows:

> *("teen pregnancy" OR "adolescent pregnancy" OR "teen birth" OR "adolescent birth" OR "teen childbearing" OR "adolescent childbearing") AND (("risk factor" OR "protective factor") OR ("conceptual framework" OR "conceptual model" OR "systematic review" OR "scoping review" OR "meta-analysis"))*

We also conducted searches using simple terms related to Activate's focal populations (e.g., "*pregnancy and juvenile justice")* in Google Scholar.

Altogether, the academic literature search resulted in 466 articles being considered for possible relevance. We screened titles of all articles and excluded 71 articles, resulting in 394 potentially relevant articles. Next, we reviewed abstracts of each article and excluded: 1) biomedical research, 2) research focused on countries outside of the U.S. or Canada, and 3) articles lacking relevance to influences on adolescent mental health or sexual and reproductive health, or the interrelationship between mental health and sexual and reproductive health. This abstract screening process eliminated 295 articles. We then conducted full-text reviews of the remaining 99 articles, ultimately keeping 51 articles. Of these, 35% (18 articles) focused on or discussed supportive adult connections, leading to this research summary being narrowed to focus on this key protective factor.

Step 2: Supplemental academic literature search

We supplemented the broad search of academic literature with additional targeted searches as needed throughout the writing process. These included searches using specific terminology (e.g., *mentor "mental health" adolescent*), reviews of reference lists in other studies, and identifying studies already known to the authors. These supplemental activities resulted in the identification of 36 potentially relevant studies. Of these, 26 received full-text review, and 15 were relevant to this research summary's focus on supportive adult connections.

Step 3: Gray literature search

We reviewed reports, briefs, and other resources from federal, non-governmental, and practitioner-oriented organizations, such as Casey Family Programs, National Network for Youth, the National Mentoring Resource Center, and the Office of Juvenile Justice and Delinquency Prevention. We conducted a high-level scan of 28 resources published by 18 organizations; of these, eight resources were relevant to the research summary's focus on supportive adult connections.

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About the Authors

Samuel Beckwith is a research scientist at Child Trends.

Brittany P. Mihalec-Adkins is a research scientist at Child Trends.

Lee Ann Huang is a senior researcher at Chapin Hall.

Shaniah Smith is a senior project manager at Child Trends and the project manager of Activate.

Julia Tallant is a research analyst at Child Trends and the Research Explorer lead for Activate.

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A Practice Guide for Promoting Youth Mental Health and Sexual and Reproductive Health as a Supportive Adult

Samuel Beckwith, Brittany P. Mihalec-Adkins, Lee Ann Huang, Shaniah Smith, and Julia Tallant

Safe, supportive relationships are critical for helping young people thrive. These can—and ideally should—include positive relationships with peers and family members. However, they can also include relationships with supportive adults outside the family, including youth-supporting professionals. Research suggests that young people who have supportive adults in their lives benefit greatly from these relationships. For example, young people who have supportive non-parental adults in their lives tend to experience better sexual and reproductive health outcomes,[1,2] have better social and emotional development,[3] and develop fewer depressive symptoms.[4]

This guide offers research-informed strategies for youth-supporting professionals to actively and intentionally promote young people's mental health and help prevent unintended teen pregnancy and negative sexual and reproductive health outcomes. It is relevant to all youth-supporting professionals, including those who support youth who experience homelessness, the child welfare system, the justice system, and/or disconnection from school and work. Young people with these experiences are more likely to face challenges accessing mental health and sexual and reproductive health resources.[5,6,7,8]

This guide:

- Describes research-informed ways of being a supportive adult to young people
- Presents common challenges young people may face and explains how supportive adults can help address them
- Provides high-level guidance for being a supportive adult

Importantly:

- Some young people may have had negative or even traumatic experiences with systems and youth-supporting professionals.
- Youth-supporting professionals and young people may have differing values, perceptions, and definitions related to "safety" and "support."
- Young people may need time before they perceive youth-supporting professionals as safe and supportive adults.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

Tips for Being a Supportive Adult

The ways adults engage with young people are critical for helping to promote positive outcomes.[9] Applying practices aligned with trauma-informed, strengths-based approaches to working with young people is helpful for building engagement and promoting well-being.[10,11] Below are five research-informed tips on how to be a supportive adult for young people, with "dos," "don'ts," and reminders for each tip.

Listen to young people.

Young people appreciate being listened to more than being lectured to.

Don't:	Make assumptions about young people's lives, experiences, or perspectives. Instead, go by what they have chosen to share with you. Don't assume or dictate how a conversation will unfold.
Do:	Demonstrate that you want to build a collaborative relationship in which the young person has a voice. Pause and ask young people if they want to hear your thoughts or suggestions before offering advice. Be open to learning from young people and their insights.
Keep in mind:	A young person's experience with you has the potential to change how they view other youth-supporting professionals or their willingness to seek help and support in the future. By listening nonjudgmentally, you can serve as a positive example of youth-supporting professionals and represent the field well.

Respect young people's priorities.

Although you bring personal and professional experience to your relationships with young people, they may want support in different areas than you initially assumed. Approaching with humility and not assuming that you always "know best" are critical for successful relationships.

Don't:	Steer young people toward your priorities while disregarding their priorities, which can suggest that you don't trust young people as the experts and drivers of their own lives.
Do:	Ask young people about the things that are important to them and their well-being-related goals. Prioritize these in your work and, over time, develop a shared understanding of how you can best support the young person's well-being.
Keep in mind:	Sometimes adults' values or opinions influence their reactions and suggestions to young people. In turn, these reactions may make a young person feel like their autonomy isn't being prioritized.

Be open and invite tough conversations.

Let young people know that they can talk to you about anything, including their mental health or their sexual and reproductive health. Even if you don't have the perfect response or immediate on-site services in these areas, a young person may not have the opportunity to get connected with needed services unless you ask. At the same time, respect young people's boundaries related to the information they choose to share with you at a specific time.

Don't:	Let worries about how to respond prevent you from asking about these topics.
Do:	Ask if they would like to discuss sexual and reproductive health or mental health topics at this time—or later, if they would prefer. Use non-stigmatizing, welcoming language (e.g., "A lot of young people wonder about this"). Offer to find and share more information or resources related to the topics young people raise.
Keep in mind:	If you are a mandated reporter, explain this early on. Include what kinds of situations you are, and are not, required to report. Explain who the young person can talk to (e.g., therapists, advocacy agency staff), what information is legally required to remain confidential, and what may have to be reported.

Connect young people to concrete resources.

To demonstrate your commitment to young people's well-being in a different way, leverage your organization's resources or your ability to navigate systems to help provide material support. Young people may be interested in a variety of resources, such as connections to other services, transportation assistance, or food support.

Don't:	Allow uncertainty about whether you can provide the help a young person needs to stop you from asking about what would be helpful. On the other hand, don't make empty promises or ask about needs without following through on offers to help identify resources.
Do:	Share how you plan to identify a resource (e.g., "I'm going to ask my team at our meeting this afternoon about who in our network can set you up with that"). Provide clear and timely updates on progress toward connecting young people with the assistance they need.
Keep in mind:	Young people may have preferences about the types of resources they use. For example, they may prefer resources located near their home for convenience, or outside their neighborhood due to concerns of stigma or shame about accessing resources. Ask about young people's preferences and try to honor them as you make connections.

Cultivate meaningful relationships with clear expectations.

Don't:	Apply these tips early on, then inconsistently afterward. Try to follow these tips in every interaction, not just when you're first establishing rapport.
Do:	Set expectations early on regarding how long you might be working with that young person, especially if your interactions will be time-limited. Openly discuss expectations and opportunities related to maintaining contact or transitioning the relationship to an informal relationship (if appropriate and desired), once your professional role in that young person's life is over.
Keep in mind:	Working with young people involves balancing both building rapport and maintaining professional boundaries. Youth-supporting professionals are responsible for guarding against inappropriate interactions or blurred boundaries with young adult clients. Consult organizational policies, supervisors, professional networks, and your profession's ethical principles to identify specific best practices for navigating this balance.

Ways Supportive Adults Can Help Youth Address Challenges

While these tips can support work with all young people, some young people face challenges that can increase their risk for both poor mental health as well as unintended pregnancy and related reproductive health outcomes. Supportive adults cannot solve all challenges. However, they can play key roles in addressing challenges by: 1) noticing warning signs, 2) talking with young people about their experiences, and 3) encouraging decisions that promote safety and well-being.

Example of challenge	Noticing warning signs	Talking with young people about their experiences	Encouraging decisions that promote safety and well-being
	What you might notice:	*How to bring it up:*	*How you can respond:*
Unsafe or unhealthy romantic relationships[12,13]	Frequent fights or breakups; isolation from others; fear of partner's emotions or responses; repeatedly shifting blame for conflict to themselves	"What feels good about the relationship, and what feels hard?" "Would you say that your relationship feels the way you want it to?" "Would it be helpful if I shared a few websites about different dynamics in teen relationships?"	*Meet young people where they are:* In general, follow young people's lead in terms of how they describe and label their relationships, rather than telling them that their relationship is unhealthy. *Identify resources:* Offer to connect them with community and online resources; share information about healthy relationships and boundaries. Offer young people contact information for domestic violence resources if needed. *Build strengths:* When appropriate and with the young person's knowledge, help identify safe adults or services for additional support.
Bullying victimization and associated psychological distress or sexual and reproductive health outcomes[14,15,16]	Reluctance to attend school or other settings with peers; references to having issues on social media	"Has anybody been giving you trouble at school—students or staff? How about online?" "Is there a teacher or other adult at school who you trust?" "What is something you wish you could change or improve about what it's like at your school?"	*Help create a safer network:* When appropriate, discuss options for involving school staff or other trusted adults; discuss how young people can use location or privacy settings to protect themselves online. *Build strengths:* Ask about supportive online and real-life peers. Create or connect young people with spaces to socialize with peers (e.g., after-school program partners).

Example of challenge	Noticing warning signs	Talking with young people about their experiences	Encouraging decisions that promote safety and well-being
	What you might notice:	*How to bring it up:*	*How you can respond:*
Barriers to accessing physical or mental health care services[17,18,19]	Missed appointments; reluctance to seek care; concerns about cost; uncertainty about how to find an appropriate provider; worries that a parent or caregiver will not allow them to seek care or will be upset if they seek care	"Is there anything that makes it hard for you to get to your appointments?" "Would you like to brainstorm options for getting you to your next appointment?" "Do you want to know more about how therapy works?"	*Offer practical help:* When appropriate, assist with transportation or scheduling; provide information about community resources; help young people with disabilities find needed accommodations. *Build strengths:* If desired, work with young people before appointments to help build confidence and self-advocacy; debrief after appointments to ensure needs are met.

Concluding Guidelines

Being a supportive adult for a young person does not require you to solve all the challenges young people are facing. Supportive adults can make a difference for young people by:

- Checking in
- Creating safe and supportive spaces for open conversation
- Providing reassurance and accurate information
- Making connections to resources and support
- Consistently recognizing and building on young people's strengths

Find more resources to help with each of these on Activate's website.

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About the Authors

Samuel Beckwith is a research scientist at Child Trends.

Brittany P. Mihalec-Adkins is a research scientist at Child Trends.

Lee Ann Huang is a senior researcher at Chapin Hall.

Shaniah Smith is a senior project manager at Child Trends and the project manager of Activate.

Julia Tallant is a research analyst at Child Trends and the Research Explorer lead for Activate.

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Harnessing Positive Peer Influence to Reduce Substance Use and Unintended Teen Pregnancy

Rachel Rosenberg, Amanda Griffin*, Karlee Naylon*, Matthew Rivas-Koehl*, and Colleen Schlecht

Introduction

Peer influence is a key factor that shapes youth's decisions and actions around substance use, sexual activity, and outcomes such as teen pregnancy. Peer influence can occur through digital communication (e.g., texting), social media or other digital spaces, or in person. Youth-supporting professionals should understand the different ways youth communicate with their peers and help youth navigate peer influence across in-person and online interactions. Because peers can influence youth in different ways, youth-supporting professionals should have the knowledge to encourage positive peer relationships and informed decision-making related to substance use and sexual activity.

Although teen pregnancy in the United States has declined over time,[1] certain groups of youth continue to experience higher rates of pregnancy relative to the general population, including youth experiencing the child welfare or juvenile justice systems, or youth experiencing homelessness.[2,3,4] Similarly, substance use rates are high among these same populations.[5,6.78,9,10,11] The high rates of substance use and teen pregnancy suggest the importance of prevention strategies that address the broader contexts shaping youth decisions. While many factors shape these decisions, peer influence is particularly important because it both increases risk and protects against substance use and risky sexual activity.[12,13] Peer norms, social acceptance, and social pressure can encourage substance use and sexual activity, but peers can also reinforce safer choices and provide positive support. For this reason, this research synthesis focuses on peer influence as a key and modifiable point of prevention. Targeting peer dynamics—for example, by correcting misperceived norms, strengthening prosocial peer networks, and building skills to resist negative peer pressure—can offer an opportunity to reduce substance use and related sexual behaviors, ultimately reducing the risk of unintended teen pregnancy.

In this summary, the term "risky sexual activity" refers to consensual sexual activity that increases the likelihood of unintended teen pregnancy or sexually transmitted infections (STIs).[14] Among

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

*The second, third, and fourth authors contributed equally to this resource and are listed in alphabetical order.

teens, risky sexual activity can include initiating sexual activity before age 14, inconsistent or ineffective use of contraception, having multiple sexual partners, and engaging in sexual activity under the influence of substances.[15,16] Research examining links between substance use and risky sexual activity has considered marijuana, alcohol, and other drugs (i.e., narcotics, opiates, amphetamines, stimulants). Given the prominence of substance use in the literature, the next section examines how substance use contributes to unintended teen pregnancy risk and why peer influence matters as a prevention strategy.[17]

Substance Use and Unintended Teen Pregnancy

Research suggests that substance use may increase risky sexual activity and related outcomes—including unintended teen pregnancy—in several ways, although the relationship between substance use and risky sexual activity is shaped by multiple connected factors.[18] For instance, personality or individual differences (e.g., impulsivity, self-efficacy, sensation-seeking), contextual factors (e.g., social norms, where behaviors take place), and interpersonal factors (e.g., family, peers) all play a role in a young person's decision-making around substance use and sexual activity.[19] Research with youth points to several ways that substance use may contribute to risky sexual activity, including links to impaired judgment (i.e., while "under the influence"), decision-making during sexual interactions,[20,21] and inconsistent contraceptive use.[22] Substance use is also associated with intimate partner violence.[23]

Impaired judgment and decision-making

Substance use is associated with greater sexual risk-taking during adolescence.[24] Research on adolescent brain development suggests that the prefrontal cortex, the region of the brain that regulates impulse control and decision-making, is not fully developed until the mid- to late 20s, indicating that youth are still developing their abilities to control impulses, think through and make safe decisions, and engage with others about those decisions.[25] Impaired impulse control may be magnified when youth use substances.[26] Specifically, alcohol and drug use may contribute to risky sexual activity by impairing judgment, inhibition, and rational decision-making among youth.[27] Alcohol can act as a catalyst for risky sexual activity, with some youth describing it as "liquid courage".[28] Further, substance use has been associated with sexual initiation before age 14,[29] and with teen pregnancy.[30]

Inconsistent or ineffective contraceptive use

Substance use is associated with inconsistent or ineffective use of contraceptives,[31,32,33] but this relationship is complex and not always direct. For example, higher levels of alcohol use are associated with lower levels of condom use.[34] However, substance use can influence behavior in ways that lead to improper or incorrect use of contraception, which can increase the risk of teen pregnancy (e.g., missed doses of hormonal contraception or incorrect condom use).[35] Additionally, substance use may impair judgment and decision-making in the moment, making it harder for young people to consider sexual risks and take steps to protect themselves.[36,37]

Substance use, intimate partner violence, and reproductive coercion

Although the focus of this research synthesis is not sexual violence, we acknowledge the serious risks associated with substance use and experiences of dating or intimate partner violence. Substance use may exacerbate intimate partner violence and reproductive coercion, both of which are associated with the risk of teen pregnancy.[38,39] However, it is important to note that while violence and substance use may occur in the same environments, substance use is not necessarily the root cause of violence. Experiencing intimate partner violence is associated with an increased risk of unintended pregnancy, including when a partner uses coercion, manipulation, or threats related to sex and pregnancy.[40,41] Reproductive coercion can occur when an individual or their sexual partner directly interferes with or sabotages contraception to reduce its effectiveness (e.g., not using or improperly using condoms, withholding hormonal contraceptives).[42] These actions undermine individual decision making and may increase the likelihood of unintended pregnancy. Some research has shown that girls and young women with current or previous foster care involvement report experiencing reproductive coercion (e.g., a sexual partner told them to not use hormonal birth control, took away their hormonal birth control, prevented them from going to a clinic, refused to use or deliberately damaged a condom) at higher rates than their peers.[43]

Importantly, substance use often occurs within social contexts that shape youth's decisions, including peers' perceptions and behaviors surrounding substance use, as well as direct peer pressure. These influences are particularly important during adolescence, when peer norms can strongly affect decision making.[44,45] At the same time, peer influence is associated with attitudes toward and engagement in risky sexual activity, further compounding risk.[46]

Peer Influence on Substance Use and Risky Sexual Activity

During adolescence and young adulthood, peer influence can shape both substance use and sexual activity.[47,48] Given the potential for unstable adult support systems, peer influences may be particularly important to consider for youth experiencing the child welfare and/or juvenile justice systems, or homelessness.[49,50,51,52]

Peer influence on substance use

Substance use behaviors can be shaped by direct peer influence (e.g., peer pressure) and perceived peer influence (e.g., beliefs about what one's peers are doing).[53] Youth often adjust their substance use behavior to align with both the actual behavior of their peers and their perceptions of peer behavior.[54] For example, youth may have inaccurate beliefs about the prevalence of substance use among their peers, which can influence their own decision-making (e.g., thinking, "All my peers are drinking, so I should too").[55,56] Research indicates that youth commonly overestimate peer alcohol use, and these inflated perceptions are associated with a higher likelihood of alcohol use.[57]

Peer influence on substance use can vary depending on the type or closeness of the peer relationship, including relationships with close friends and romantic partners versus acquaintances or broader peer networks. Close friends tend to shape behavior through shared norms, expectations, and day-to-day social interactions, while broader peer groups influence behavior through perceived norms and social desirability.[58] For example, if members of a close friend group regularly drink at parties and view this behavior as typical, other member may feel increased pressure to engage in similar behaviors. In contrast, a young person may believe that "most people at my school are hooking up and not using condoms," based on

social media posts, rumors, or high-visibility peers. Even without direct pressure, perceptions about what is common or socially accepted can influence behavior to align with perceived norms.

Peer influence on substance use may be especially important for youth whose relationships with supportive adults are limited or unstable, such as youth who experience the child welfare system, juvenile justice system, or homelessness. A qualitative study of youth between ages 16 to 21 who were experiencing homelessness found that social networks shape substance use norms through shared patterns of use, perceptions of drug-related safety, encouragement or discouragement of use, and beliefs about when and where substance use is socially acceptable.[59] For youth transitioning out of foster care, exposure to peer groups engaging in risky activities and exposure to broader neighborhood-level stressors were identified as risk factors for using multiple substances, even after accounting for family and other supports.[60] Similarly, among young people experiencing homelessness who had previously been in foster care (average age: 22), a greater number of foster care placements was associated with an increased likelihood of having peers who used methamphetamine in their social networks.[61] This finding highlights how placement instability may disrupt stable, supportive relationships and contribute to greater reliance on peer networks in which substance use is more prevalent, thereby increasing the risk of substance use.[62] Finally, among youth involved in the juvenile justice system, both family and peer substance use have been shown to increase the risk of alcohol and illicit drug use, through direct exposure to substances and the development of "pro-drug" attitudes.[63] Pro-drug attitudes refer to beliefs that substance use is common, socially acceptable, or low risk (e.g., "Everyone drinks" or "It's not a big deal"), often shaped by perceived peer norms and perceived approval of use.[64,65]

Example: If a young person's close friends regularly drink at parties, they may feel pressure to join them.

Takeaway: What feels normal in a friend group can shape a young person's choices about drinking and sex.

Collectively, this body of research highlights peers as a central influence on substance use, particularly among youth experiencing different types of instability and system involvement.

Peer influence on sexual behaviors

Peer influence on adolescent and young adult sexual activity operates through both direct peer pressure and indirect peer influence (e.g. peer norms and expectations about what sexual behaviors are typical or socially acceptable).[66] For example, a recent meta-analysis examining peer norms and adolescent sexual activity highlighted the multiple ways peers shape risky sexual activity.[67] Research indicates that youth are more likely to engage in sexual activity when they perceive that their peers are sexually active, approve of sex, or pressure them to engage in sexual activity. The same study found that theses associations are strongest when youth perceive these norms among close friends rather than broader peer groups.[68] Notably, beliefs about what peers do (i.e., descriptive norms) have been found to be more strongly associated with sexual activity than beliefs about what peers approve of (i.e., injunctive norms) or direct peer pressure related to sex. This suggests that adolescents may be more influenced by observed or assumed peer behaviors than by explicit expectations or verbal encouragement.

Peer influence is particularly important for youth in the child welfare or juvenile justice systems or youth experiencing homelessness because they rely more heavily on peers for support. Among youth who had experienced maltreatment, earlier pubertal development (ages 9 to 13) was associated with engagement with peers who used substances (i.e., alcohol or marijuana), which, in turn, was associated with an increased risk for substance use and sexual activity.[69] Similarly, among youth experiencing homelessness, those whose networks include people with multiple simultaneous partners or who engage in unsafe sex are more likely than their peers whose networks do not include people engaging in these behaviors to have multiple simultaneous partners or engage in unsafe sex.[70] Youth who experienced homelessness prior to exiting

foster care, compared to those who did not experience homelessness, are more likely to be connected to peers who engage in risky sexual activity including sex without a condom.[71]

Conversely, perceived peer use of condoms during sexual activity is associated with lower risk. Among youth experiencing homelessness, perceiving higher levels of peer condom use or safer sex practices is associated with reduced odds of engaging in sex without a condom.[72] Regarding pregnancy-related attitudes, youth experiencing homelessness who perceive their "street-based peers" (i.e., peers also experiencing homelessness) or serious romantic partners as disapproving of pregnancy, compared to approving of pregnancy, are significantly less likely to endorse positive attitudes toward becoming pregnant.[73]

Together, these findings suggest that peer and partner norms—both risk-promoting and protective—play a significant role in shaping adolescents' sexual activity and pregnancy-related attitudes.

Increasing Positive Peer Influence and Interrupting the Link Between Substance Use and Risky Sexual Behavior

Positive peer norms and support

Peers can play a protective role by reinforcing safer norms and expectations related to sexual activity and substance use. Youth whose peer networks both promote safer sexual practices (e.g., contraception use, non-judgmental attitudes toward abstinence, and norms supportive of delaying sexual activity) and discourage substance use engage in risky sexual behaviors at lower rates, underscoring the protective role of positive peer influence.[74,75,76] In one study, having someone to talk to when feeling sad was associated with lower levels of risk-taking behaviors among youth who are stably housed, including substance use and sexual activity. However, among youth experiencing housing instability, the same form of social support was associated with higher levels of risk-taking behaviors, suggesting that the protective function of support may depend on broader contextual factors.[77] Taken together, this body of research suggests that peer influence can contribute to increased risk when peers model or reinforce risky activity, but can also serve as a protective factor when peers model and promote safer activity and contribute to supportive norms.

Using peer leaders in substance use and teen pregnancy prevention programming

The research presented above suggests that peers may play a valuable role in programming focused on substance use and teen pregnancy prevention. For youth who experience the child welfare or juvenile justice systems, or youth experiencing homelessness, peer influence may be especially important because relationships with supportive adults or caregivers may be disrupted by instability or system involvement. For example, a study of adolescent girls in a residential care setting found that girls in the sample had stronger ties to peers than to caregivers and that these peer relationships were sometimes associated with

negative influences on substance use and sexual activity.[78] At the same time, this research provides support for the idea of using positive peer networks as a prevention approach to minimize substance use and risky sexual activity that can lead to unintended teen pregnancy.[79] For example, adolescents and young adults who model or encourage substance-free behaviors can discourage alcohol and drug use among their peers.[80,81] Peer influence was a key factor in the success of an alcohol and tobacco use prevention program across a large sample of adolescents.[82] In a study that gathered input on intervention strategies for preventing unintended pregnancy and STIs directly from youth in foster care, youth supported the inclusion of peer facilitators who shared past experiences and helped build positive peer networks.[83] Collectively, these findings suggest that youth may benefit from programming that includes peer leaders who engage them in dialogue and counter direct or perceived negative peer pressure.

The resources below provide more information on implementing peer facilitation into your work with youth:

1. Peer Facilitation: Accelerating Individual, Community, and Societal Change
2. Promoting Peer Support in Child Welfare
3. Advancing the Work of Peer Support Specialist in Behavioral Health-Criminal Justice Programming
4. Expanding Peer Support Roles in Homeless Services Delivery: A Toolkit for Service Providers
5. Perspectives on Young Parents as Peer Educators in a Teen Pregnancy Prevention Program
6. Peer Education for Adolescent Reproductive and Sexual Health
7. Part 1 of Peer Support Group Facilitation Skills for Peer Specialist in Veterans Health Administration

Conclusion

The literature reviewed in this summary suggests that peers can heighten the level of risk when substance use, unprotected sex, or supportive attitudes toward pregnancy are normalized within youths' social networks. At the same time, peers can function as important protective influences when they model safer behaviors, reinforce contraception use, discourage substance use, and communicate norms that support healthier decision-making. Taken together, this research suggests that efforts to reduce unintended teen pregnancy should consider not only individual knowledge and behavior change, but also peer networks and social contexts that shape youth's decisions. Further, because peer relationships influence both sexual activity *and* substance use, prevention strategies that address peer influence may help reduce substance use and the risk of unintended pregnancy. More information and practice-based strategies for working with youth to harness positive peer influence and reduce substance use and risky sexual activity are available in this related technical assistance tool: A Technical Assistance Tool for Helping Youth Navigate Peer Influence.

In sum, harnessing positive peer influence through peer-led programming, supportive social networks, and strategies that shift peer norms may be a promising way to reduce substance use, support safer sexual decision-making, and ultimately reduce the risk of unintended teen pregnancy.

Methods

This research summary was supported by an extensive review of existing peer reviewed research and grey literature. We conducted systematic searches using EBSCO and Google Scholar. The first 5 pages of the results were exported to identify literature on peer and social influences on sexual decision-making and pregnancy prevention among adolescents and young adults, and how this intersects with substance use. We filtered results to include only English-language publications involving United States-based samples published in peer-reviewed journals from 2015 to 2026. To the extent possible, we narrowed the literature

search to focus on the following populations: young people experiencing child welfare or the juvenile justice systems, homelessness, or disconnection from work and school. We used the following key terms: teen pregnancy prevention, unwanted pregnancy, risky sexual behavior, peer influence, peer pressure, and social influence. We then conducted a search using each of these key terms in combination with terms to describe the populations (e.g., adolescent, young adult, aging out of foster care, and former foster youth).

We also conducted supplemental searches for literature examining peer influence on sexual decision-making and the relationship between substance use and pregnancy prevention or sexual risk. These searches expanded the terminology to include peer networks and norms; additional sexual and reproductive health terms such as contraception, condom use, sexual initiation, and unprotected sex; and specific substance use terms such as alcohol, cannabis, tobacco, nicotine, and other drug use. For the supplemental search, we prioritized literature published within the last 10 years, though some older articles were retained because of their unique contributions or distinct relevance to the research summary.

We screened out articles not closely related to the focal topic. We then developed an outline and sought feedback from the Activate Research Alliance comprised of youth with lived experience, youth-supporting professionals, program administrators, researchers, and policymakers. We made revisions based on their feedback and proceeded to develop the full research summary and accompanying resource: A Technical Assistance Tool for Helping Youth Navigate Peer Influence.

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About the Authors

Rachel Rosenberg, PhD, is a senior research scientist at Child Trends.

Amanda M. Griffin*, PhD, is a researcher at Chapin Hall.

Karlee Naylon*, MPP, is a senior research analyst at Child Trends.

Matthew Rivas-Koehl*, PhD, is a research scientist at Child Trends.

Colleen Schlecht, MPP, is a senior researcher at Chapin Hall.

*The second, third, and fourth authors contributed equally to this resource and are listed in alphabetical order.

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A Technical Assistance Tool for Helping Youth Navigate Peer Influence

Rachel Rosenberg, Amanda M. Griffin,* Karlee Naylon,* Matthew Rivas-Koehl,* and Colleen Schlecht

Peer influence plays a critical role in shaping youth's[a] experiences and behaviors. Peer influence can include direct pressure from peers, perceived peer norms about what "everyone" is doing, digital influences, and the influence of close friends' attitudes and behaviors—influences that can be both positive and negative. Peer influence is particularly important in relation to substance use and risky sexual activity, which can increase the risk of unintended teen pregnancy.[1,2,3] Youth-supporting professionals can help youth develop positive peer networks that support healthier decisions about substance use, sexual activity, and contraception use.[4,5,6]

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare or justice system, homelessness, or disconnection from school and work (i.e., opportunity youth).

This tool provides practical, research-informed strategies that youth-supporting professionals can use to help youth recognize and respond to negative peer influence, strengthen positive peer connections, and make safe decisions related to substance use and sexual activity. This resource builds on previous Activate resources[7,8] that focus on helping youth-supporting professionals build trust and rapport with youth before engaging in difficult conversations, such as conversations about substance use and risky sexual activity.

Why Peer Influence, Substance Use, and Risky Sexual Activity Can Be Addressed Together

Substance use is linked to risky sexual activity, including engaging in sexual activity when judgement and decision-making are impaired,[9,10] sexual initiation before age 14,[11] inconsistent contraceptive use,[12] coercive sexual encounters,[13] and sex with multiple partners.[14] These sexual activities increase the risk of unintended teen pregnancy and sexually transmitted infections (STIs).[15]

Research shows that peer influence can shape both substance use and risky sexual activity. For example, when asked about their peers broadly, youth often overestimate alcohol use among their peers, which can make alcohol use[b] seem more normative.[16,17,18] Research further shows that close friends shape norms through everyday interactions and shared expectations.[19] For example, youth may be less likely to try substances when their close friends do not use them. Peers can also shape norms and behaviors related to sexual activity and contraception use.[20] Youth who perceive that their peers are sexually active or approve of sexual activity are more likely to engage in sexual activity than those who do not share these perceptions.[21] Peer influence on substance use and sexual activity may be particularly important for youth experiencing the child welfare system, juvenile justice system, or homelessness. Young people in these

*The second, third, and fourth authors contributed equally to this resource and are listed in alphabetical order
[a] Throughout this resource, we use youth to refer to all adolescents and young adults ages 14-24.
[b] Alcohol is the most commonly studied substance when examining the relationship between substance use and sexual activity.

settings are more likely to experience disruptions in their connections to stable, supportive adults, due in part to placement instability, and may consequently rely on peers for emotional support and guidance.[22,23,24,25,26,27] Together, this research suggests that youth-supporting professionals can help youth recognize and respond to peer influence and build peer relationships that support safer decisions.

Strategies for Helping Youth Address Peer Influence Related to Substance Use and Risky Sexual Activity

Below we describe four strategies that youth-supporting professionals can use to help youth resist negative peer influences (i.e., peer pressure) and strengthen positive peer influences related to substance use and sexual activity. For each strategy, we include guidance on how to apply it in practice. The strategies are intended as general guidance and may need to be adapted based on the circumstances and experiences of the youth you are working with.

Help youth recognize and name negative peer influence.

Youth may experience negative peer influence (i.e., peer pressure) from friends, romantic partners, or acquaintances to use substances or engage in risky sexual activities.[28,29] This peer pressure can occur in person or through digital communication, such as text messaging, social media, or other platforms and apps.[30,31] Youth may sense when this is happening but lack the language to describe it. Helping youth recognize and name this peer pressure is an important first step in building their ability to respond effectively. To help youth name the kinds of peer pressure they experience, youth-supporting professionals can:

- Help youth identify **what** negative peer influence looks like. Negative peer influence can include peer pressure, as well as peer approval of risky behaviors or peer engagement in risky behaviors without directly pressuring others to join in.
    - "Do you feel pressured to engage in certain activities when you see your peers posting on social media about those activities?"
- Ask questions to help youth identify **who** is pressuring them to make risky choices and/or who is encouraging them to make safer choices.
    - "Is anyone in your life pushing you to do something you don't want to do?"
    - "Who do you look to for examples of how you want to be or things you want to do?"
- Ask questions to identify **where** youth are experiencing peer influence. For example, is it happening in a residential care setting, at home, or at school?
    - "Where do you feel like you have the most freedom to make your own choices?"
    - "Are there certain places where you feel you have to do what your friends expect you to do?"
- Help youth **connect** their experiences to their feelings and choices. Youth may not always label an experience as feeling peer pressured, but they may connect it to feelings such as nervousness, guilt, or embarrassment.
    - "How did you feel in your body when that situation happened?"
    - "What made it feel hard to do what you wanted to do?
- "Did you feel like you would be judged or let someone down if you didn't do that?"

What can you do to help youth name the kinds of peer influence they experience?

Start by creating a trusting, nonjudgmental space where youth feel comfortable sharing. Use open-ended questions and real-life scenarios to help them reflect on situations where they may feel pressured or influenced by peers, and introduce clear, age-appropriate language to describe what they may have experienced. This process can help youth recognize what is happening, describe it in their own words, and consider how they want to respond.

Teach and practice refusal and boundary-setting skills.

Youth are more likely to resist peer pressure when they have simple, prepared responses.[32,33,34,35] Teaching youth refusal skills can help them navigate situations where they feel pressured to use substances or engage in risky sexual activity by giving them strategies to avoid or exit these situations.[36,37,38] Refusal skills include being direct, giving reasons for not participating in an activity, redirecting to alternatives, using external excuses, or using humor. Youth-supporting professionals should also work with youth on respecting and responding to boundaries regarding substance use and sexual activity set by others. Boundary-respecting skills include recognizing and honoring when others express discomfort or say no and understanding that respecting others' boundaries is as important as asserting one's own. Youth-supporting professionals can help youth practice the S.T.O.P. approach to saying no, which includes setting boundaries and responding to peer influence with clear communication.[39]

What can you do to teach and practice refusal and boundary-setting skills?

Role-play with youth so they can practice setting and respecting boundaries in a low-stakes environment. Support youth in identifying and clarifying their boundaries before they are in a situation where they need to assert them. Reinforce that setting boundaries includes both expressing their own limits and recognizing and respecting others' boundaries. Prepare youth for real-world challenges by practicing how to respond when someone ignores or pushes past their boundaries, including when to disengage or seek support.

Provide accurate information about peer norms and substance use trends.

Youth may underestimate or be unaware of the risks associated with substance use and unprotected sex. Youth can also hold inaccurate beliefs about how common these behaviors are among their peers, and this can influence their own choices.[40] Providing accurate, relevant information in a nonjudgmental way can help youth better understand what their peers are actually doing, what risks may be involved, and how to make safe choices.[41,42]

It is important for youth-supporting professionals to stay up to date on information, including the slang or "street names[43]" for drugs, and to understand[44] how those drugs impact the body. In addition, information about regional and national trends on substance use among youth can be helpful. For more information on how to track trends in your community, see the list below. These resources can help professionals stay informed and discuss trends with youth in accurate, nonjudgmental ways:

- Monitoring the Future is an ongoing study at the University of Michigan that conducts annual surveys of more than 25,000 adolescents and young adults on attitudes and behaviors related to drug use. The project regularly publishes data on prevalence and emerging trends.[45]
- The Youth Risk Behavior Surveillance System (YRBSS) is the largest public health monitoring system in the United States focused on high school students. YRBSS tracks and publishes health-related behaviors, including sexual behavior, substance use, and social media use.[46]
- The National Survey on Drug Use and Health (NSDUH) provides nationally representative data on substance use, substance use disorders, mental health, and receipt of substance use and mental health treatment among U.S. residents age 12 and older. NSDUH data are used to generate national, regional, and state-level prevalence estimates, which can be viewed by age group on interactive maps.[47]

Youth-supporting professionals do not need to present detailed data on sexual behavior and substance use to youth. Instead, they can use information to answer questions accurately, correct misperceptions about what "everyone" is doing, and connect youth to credible information when needed.

What can you do to provide accurate information about peer norms and trends related to substance use and sexual activity?

Talk with youth openly about different substances, the different names they are called, how they affect the body and mind, and their risks and side effects. Youth may use slang or euphemisms, so stay up to date on slang and jargon used in your community Discuss questions about sexual activity using accurate language and in a non-stigmatizing way. When youth say that "everyone" is using substances or having sex, respond with curiosity and accurate information rather than judgment. For example, the scenario below shows how a youth-supporting professional might correct a misperception while talking with a young person:

- ***Youth:*** *Everyone drinks at parties. If you don't, you're basically the only one.*
- ***Professional:*** *It can definitely feel that way, but actually a lot of teens don't drink at all or drink less than people think. Research shows that many high school students choose not to drink.*
- ***Follow-up:*** *Do you feel like it's really everyone, or just certain groups of people?*

Encourage youth to build prosocial peer relationships.

Prosocial peers are those who generally support or help others and model positive behaviors; research suggests they can help protect against substance use in their peer groups.[48,49] When youth are surrounded by peers who value safety, respect boundaries, and engage in positive activities, they are less likely to be encouraged to use substances or to see substance use as acceptable.[50] In prosocial peer groups, youth encourage one another to make healthy, safe, and constructive choices, such as helping others, respecting boundaries, and discouraging harmful behaviors.[51] Relationships with prosocial peers, such as peer-to-peer mentors, are associated with positive social, academic, and health-related behaviors.[52,53]

Prosocial peer relationships can encourage youth to:[54,55,56]

- Spend time with friends who respect their choices.
- Support friends who say no to substances or unsafe sex.
- Create group norms around safety and respect.

Prosocial peer relationships can also create a strong sense of belonging, which can reduce the pressure some youth may feel to seek acceptance through engaging in peer pressure (including related to substance use or sexual activity).[57,58,59,60] In this way, prosocial peer relationships serve as both a buffer against negative influences and a source of support that promotes resilience and well-being.

What can you do to encourage youth to build prosocial peer relationships?

Create opportunities for youth to take on meaningful leadership roles, such as co-facilitating activities or discussions with other youth. Support youth in building skills that strengthen positive relationships, including how to initiate contact, check in on friends, and maintain supportive connections. Teach and give youth opportunities to practice ways to recognize and respond to harmful or risky peer behaviors, including how to speak up safely or seek help from a trusted adult when needed.

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About the Authors

Rachel Rosenberg, PhD, is a senior research scientist at Child Trends.
Amanda M. Griffin,* PhD, is a researcher at Chapin Hall.
Karlee Naylon,* MPP, is a senior research analyst at Child Trends.
Matthew Rivas-Koehl,* PhD, is a research scientist at Child Trends.
Colleen Schlecht, MPP, is a senior researcher at Chapin Hall.
*The second, third, and fourth authors contributed equally to this resource and are listed in alphabetical order.

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ACTIVATE

A partnership between
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Conversation Strategies for Talking With Young People About Healthy Relationships

Matthew Rivas-Koehl, Mindy E. Scott, & Dane Rivas-Koehl

Child Trends

CHAPIN HALL

Activate partners with youth-supporting professionals, young people, and researchers to translate research and create research-based resources for professionals who support young people experiencing the justice system, the child welfare system, homelessness, or disconnection from school and work.

Training Goals

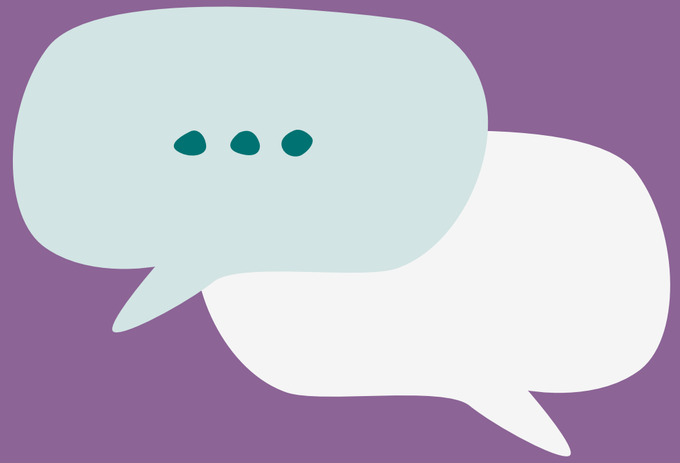
Introduce four key elements of healthy adolescent relationships

Share how to apply knowledge about these elements of healthy relationships in your conversations with youth

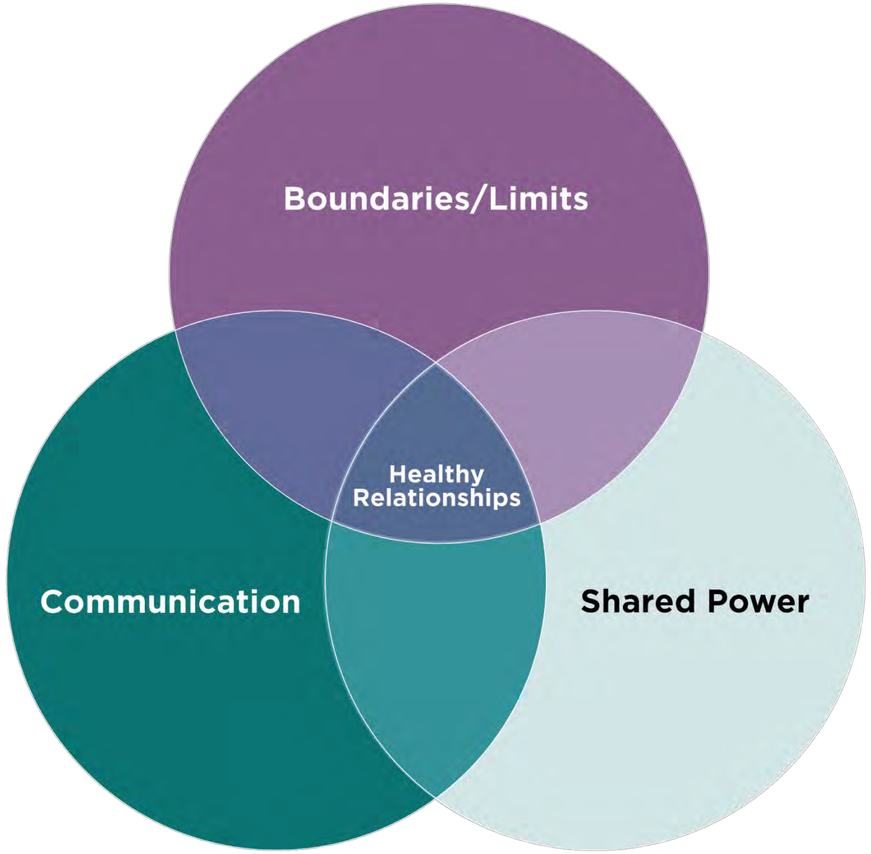
Discuss how to navigate aspects of youth relationships in the context of technology

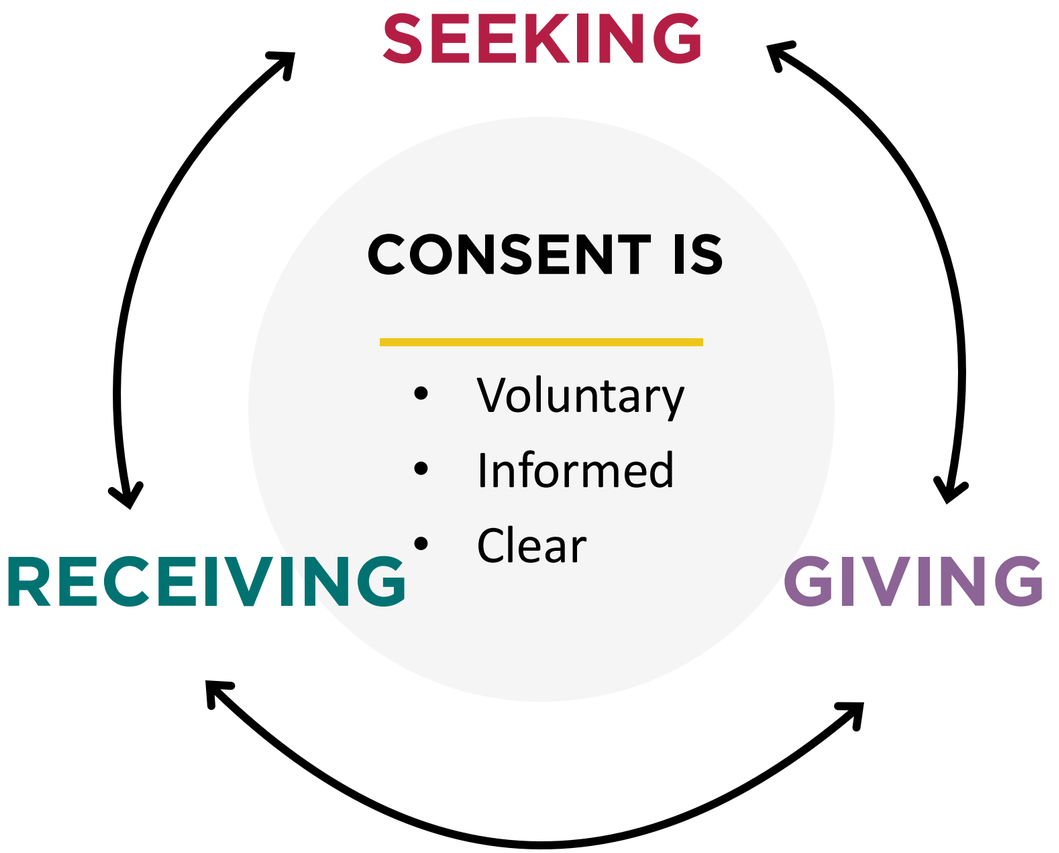
Handout Exercise 1

Reflecting on Talking With Young People



Healthy Relationships





Healthy Communication:

What to Know

What Does Healthy Communication Look Like?

Active Listening

- Listening to understand, not just to respond

Clarity

- Clearly stating what you mean/your intentions
- Intentionally trying to see another perspective
- Not making assumptions

What Does Healthy Communication Look Like?

Emotional Regulation

- Being able to pause and come back to a conversation

Open to Repair

- Recognize missteps, apologize, compromise, and work to rebuild trust

Respect

- Handle sensitive topics with respect

Healthy Communication:
Talking With Young People

Model Healthy Communication

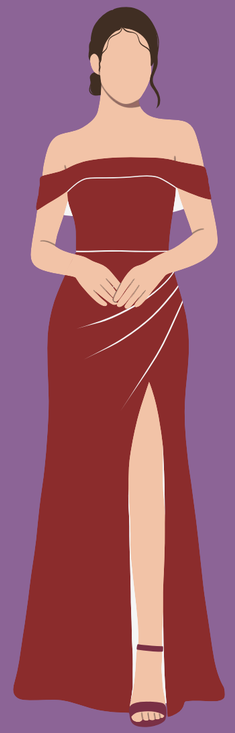
Ask direct questions to understand young adults' relationships

Avoid making assumptions about their experiences

Practice active listening using phrases

Handout Exercise 2

Is this a communication issue,
a power issue, or both?



Shared Power:
What to Know

What Does Shared Power Look Like?

1. Decisions made together
2. Each person’s needs matter
3. No one dominates, controls, or punishes to get their way

Shared Power:
Talking With Young People

Listen, Reflect, Explore

Listen

- What happened?
- How did it make you feel?
- Did you feel you had a choice?

Reflect

- What I am hearing is that you felt pressured. Is that right?

Explore

- What would shared power have looked like in the decision-making process about your dress?

Boundaries:

What to Know

Four Types of Boundaries

Physical

Touch, affection, sex, personal space

Emotional

Sharing feelings, privacy around past experiences

Material

Money, possessions, phone access

Mental

Beliefs, opinions, values

Boundaries:

Talking With Young People

Strategies for Talking With Young People About Boundaries

Talk about boundaries in general before discussing boundaries in dating relationships

Consider asking youth to reflect through written prompts and share what they are comfortable sharing. For example:

- “What are 3 things that are deal-breakers for you in a relationship (e.g., breaking promises, other actions you won’t tolerate)?”
- “What’s one thing you do not share (e.g., clothes, phone, location)?”

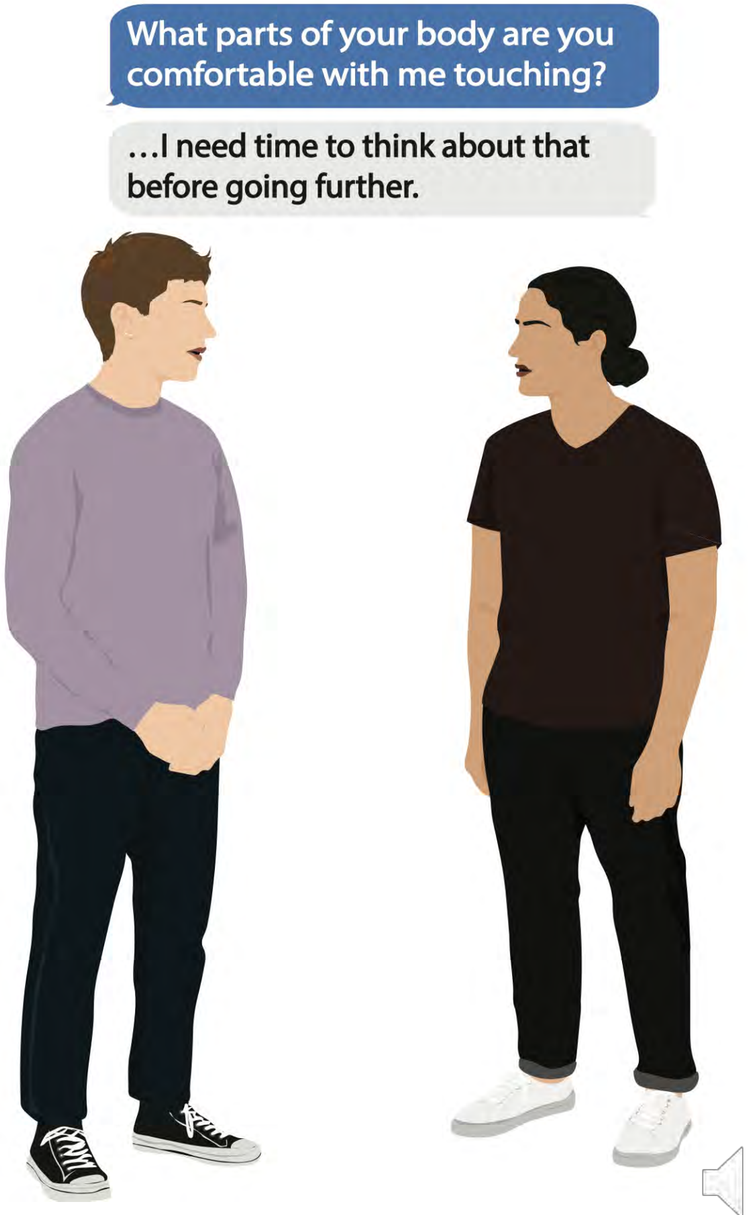
Handout Exercise 3

Helping Young People Reflect on Boundaries

Consent:
What to Know

What Is Consent?

- Voluntary, informed agreement
- Ongoing and can change at any time
- Pressure, fear, or impairment cannot lead to consent
- Verbal and nonverbal
- The absence of a “no” does not mean “yes”



Consent:

Talking With Young People

Ways Young People Communicate Consent

Type of Communication	Giving consent to engage in/continue sexual activity (*Examples*)*	Declining to engage in/continue sexual activity (*Examples*)*
Verbal cues only	**Providing direct, spoken communication agreeing to an activity**[35,36]	**Saying clearly and directly that you do *not* want to do something**
	Before: *"Yes, I'd love to do that!"*[37] **During:** *"I really like this! I'd love to keep going."*[38]	**Before:** *"No, I'd rather not do that."*[39] **During:** *"I'm not having fun anymore. I want to stop."*[40]
Nonverbal cues only	**Displaying actions and/or body language to show you're comfortable, interested, and/or in agreement with the activity**[41]	**Displaying actions and/or body language to show you're uncomfortable, not interested, and/or not okay with the activity**
	Before: *Excitedly nodding when someone suggests an activity in which you'd like to engage.*[42] **During:** *Taking a step closer or holding someone tighter during an interaction such as a hug.*[43]	**Before:** *Frowning and shaking your head or moving away when someone suggests an activity in which you do not want to engage.* **During:** *Pulling away from an interaction or pushing someone's arms or hands away.*[44]
Verbal *and* nonverbal cues	**Using words <u>and</u> body language to show agreement**	**Using words <u>and</u> body language to show refusal**
	Before: *"Yeah, a hug sounds nice," while opening your arms.*[45] **During:** *"This is nice," while leaning into the person you are hugging.*[46]	**Before:** *"No, I don't want a hug," while stepping away.*[47] **During:** *"Please let go," while pulling away from a hug.*[48]

Source: Rosenberg, R., Rivas-Koehl, M., Mihalec-Adkins, B., Schlecht, C., Parekh, J., & Rivas-Koehl, D. (2025). A Practice Guide for Understanding Consent. Child Trends.
Note: The examples provided in the table are informed by research included in an accompanying research synthesis.

Handout Exercise 4

Helping Young People Practice Consent

Healthy Relationships and Technology:

What to Know

Technology and Relationships—Risks and Opportunities

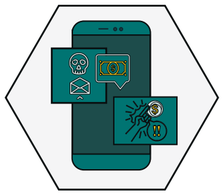
Technology can facilitate community and connection, but can also expose youth to harm

Things for youth-supporting professionals to be aware of include:

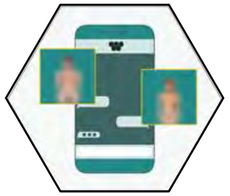
- Sexual cyberbullying and digital red flags
- Misinformation and disinformation

Sexual Cyberbullying: What Is It?

Sexual cyberbullying is a broad term used to describe any sexually aggressive or coercive behavior facilitated by technology to intentionally harm, embarrass, threaten, or intimidate another person.



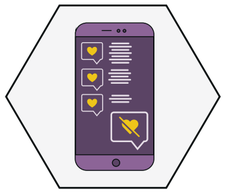
Sextortion: Receiving or sending a message claiming that an explicit image will be shared online unless one complies with the sender's request



Revenge porn: Distributing photographs or videos of an ex-partner, obtained via hacking or other methods

Online sexual harassment: Receiving or sending an unsolicited message on Instagram asking about what someone likes/is into sexually

Cyberstalking: Receiving/sending messages through a social media platform that one is being watched



Nonconsensual sexting: Receiving or sending a naked picture on Snapchat without consent

Cyberdating abuse: Finding hurtful comments about one's body on a partner's Instagram post

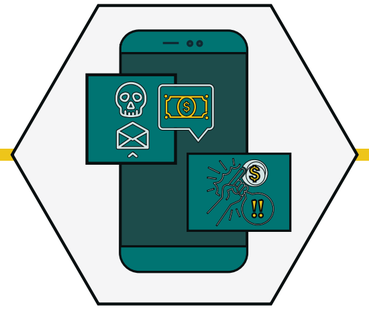
Source: Schlecht, C., Griffin, A.M., Rosenberg, R. (2024). How to decode signs of sexual cyberbullying and support teens and youth. Child Trends.

Sexual Cyberbullying Behaviors

SEXTORTION

WHAT IS THIS BEHAVIOR?

Non-physical way of forcing sexual favors by threatening to reveal evidence of someone's sexual activity.[9]



WHAT COULD IT LOOK LIKE?

Receiving or sending a message claiming that an explicit image (e.g., a nude) will be shared online unless one complies with the sender's requests.[10]

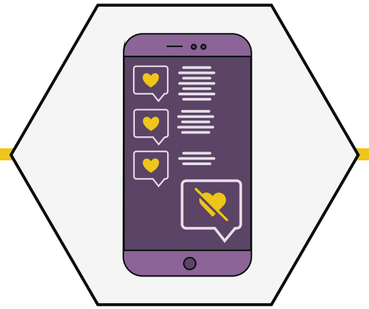
ONLINE SEXUAL HARASSMENT

Unwanted sexual behavior on any digital platform.[11] This can occur between anyone, including family, friends, acquaintances, or strangers.

Receiving or sending an unsolicited message on Instagram asking about what someone likes/is into sexually.

NONCONSENSUAL SEXTING

Nonconsensual texting of sexually explicit messages or photos.[12] This can occur between anyone, including family, friends, acquaintances, or strangers.



Receiving or sending a naked picture on Snapchat without consent.

Source: Schlecht, C., Griffin, A.M., Rosenberg, R. (2024). How to decode signs of sexual cyberbullying and support teens and youth. Child Trends.

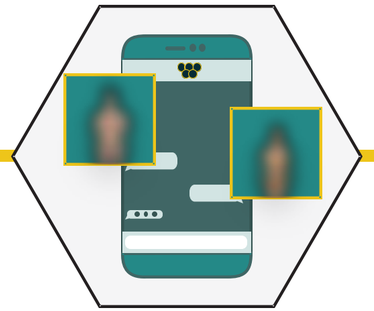
Sexual Cyberbullying Behaviors

WHAT IS THIS BEHAVIOR?

WHAT COULD IT LOOK LIKE?

REVENGE PORN

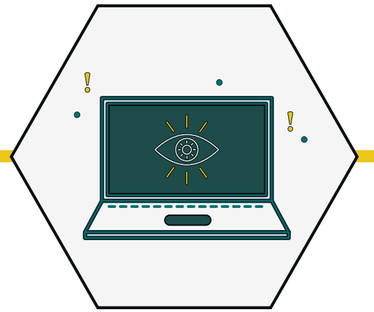
Revealing sexually explicit images or videos of a person on the internet without the consent of the subject to cause them distress or embarrassment.[13]



Distributing photographs or videos of an ex-partner, obtained via hacking or other methods. Finding an explicit image or video of oneself that an ex-partner posted without consent after a breakup.

CYBERSTALKING

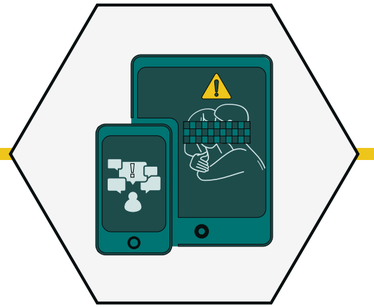
Using technology to repeatedly threaten, harass, or intimidate another person, making the other person concerned about their safety.[14] This can occur between anyone.



Receiving/sending messages through a social media platform saying that one is being watched. This includes watching someone's social media to learn where they are and arriving uninvited.[15]

CYBERDATING ABUSE

Using technology to spread negative information (e.g., spreading rumors, talking badly about their body) or to direct aggression or control toward an intimate partner or romantic interest.[16]



Spreading rumors about a partner or romantic interest's sexual identity/orientation on an online gaming chat room. Or, finding hurtful comments about one's body on a partner's Instagram post.

Source: Schlecht, C., Griffin, A.M., Rosenberg, R. (2024). How to decode signs of sexual cyberbullying and support teens and youth. Child Trends.

Healthy Relationships and Technology:

Talking With Young People

Helping Young People Think About Healthy Relationships in a Digital World

Sample prompts

- “How do you and your partner use social media in your relationship?”
- “How fast is ‘fast enough’ to reply to a message or text?”
- “What would you do if someone pressured you to send a photo you did not want to?”

How youth can communicate digital boundaries to partners

- “I’m not sharing my password.”
- “I’m busy. I’ll reply when I can.”
- “Don’t post me without asking.”

Increase access to and use of accurate, research-informed information

Handout Exercise 5

Healthy Relationships in Digital Spaces

Final Considerations

Final Considerations

Balance between guiding young people and respecting their autonomy

Meet young people where they are

You don’t need to know everything

Stay Informed!

Website: activatecenter.org/

LinkedIn: linkedin.com/company/activate-collective

Acknowledgements: The authors would like to thank the many contributors to this resource. Experts who informed the resource include Chris Drescher and Morrigan Hunter. We also thank other Activate project team members who assisted in the development of this resource, including Amy Dworsky (co-Principal Investigator) and April Wilson (Project Director). We are grateful for the support of Child Trends staff who contributed to this resource, including Gabriella Guerra, Karlee Naylon, Kristen Harper, Marta Alvira-Hammond, Olga Morales, Catherine Nichols, Brent Franklin, and Stephen Russ.

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Conversation Strategies for Talking With Young People About Healthy Relationships

Participant Training Guide

Name: _____ Date: _____

How to use this handout

Use this handout while watching the pre-recorded training. When prompted, pause the video, write your responses, and then resume. The goal is not to have perfect answers; rather, it is to practice asking questions that center young people's perspectives and experiences, identify healthy and unhealthy relationship dynamics, and plan how you might use these strategies in your own setting.

Learning objectives

- Describe key elements of healthy adolescent relationships.
- Use practical conversation strategies to talk with young people about healthy relationships.
- Help young people safely navigate digital-based relationships.

Exercise 1: Reflecting on talking with young people (Slide 5)

Before the training moves into strategies, take a moment to think about why conversations about healthy relationships can be challenging for youth-supporting professionals.

What can make it difficult to talk with young people about healthy relationships?

What do you want young people to feel during these conversations with you?

Safety reminder

If a situation may involve interpersonal violence, coercion, stalking, threats, sexual exploitation, or fear of retaliation, prioritize safety and follow your organization's reporting, referral, and safety-planning protocols. Do not put responsibility on a young person to confront someone when doing so may increase the level of risk to them.

Exercise 2: Is this a communication issue, a power issue, or both? (Slide 14)

Scenario: Jordan tells Kate that she should wear a certain dress to prom. Kate wears the dress even though she does not want to because she is not sure how to discuss the issue with Jordan.

2A. What additional information would you need?

Area to explore	Questions to consider
Choice and pressure	Did Kate feel like she could say no? Was she worried about how Jordan would respond?
Pattern over time	Has Jordan made decisions for Kate before? Does this happen with clothes, friends, social media, money, transportation, or plans?
Reaction to disagreement	What happens when Kate disagrees with Jordan? Does Jordan listen, become angry, guilt-trip her, threaten her, or punish her?
Safety and fear	Is Kate afraid of Jordan? Has there been intimidation, monitoring, threats, or physical harm?
Support and autonomy	Who does Kate feel comfortable talking to? What would she want to do next?

2B. Draft follow-up questions for Kate that center the perspective of young people.

Write questions that are open-ended, nonjudgmental, and grounded in curiosity. Before you fully understand the situation, avoid assuming that Kate is overreacting or that Jordan is abusive or telling Kate what to do.

Questions for Kate:

2C. Draft a prompt Kate could use with Jordan, if it feels safe to her.

In real situations, first consider whether it would be safe for the young person to raise the issue directly.

One thing Kate could say to Jordan:

Sample follow-up questions you could adapt:

- How did you feel when Jordan told you what to wear?
- Did you feel like you had a choice?
- What do you think would have happened if you had said you wanted to wear something else?
- Is this the kind of thing that has happened before, or did it feel unusual?

Sample prompts Kate could adapt:

- When you told me what to wear, I felt pressured. I want us to make suggestions without making each other feel controlled.
- I am open to hearing your opinion, but I want the final choice about my clothes to be mine.
- Next time, can we talk about what we each like without making it feel like one person gets to decide?

Exercise 3: Helping young people reflect on boundaries (Slide 23)

3A. Write general boundary-related questions you could ask young people.

Try to write questions that do not require young people to disclose personal experiences unless they choose to.

Questions about everyday boundaries:

Questions about relationship boundaries:

Examples of boundary reflection questions

Boundary focus	Questions young people could reflect on
Values and deal-breakers	• What are three things that help you feel respected in a relationship? • What is one deal-breaker for you in a friendship or dating relationship?
Physical boundaries	• How do you know when physical affection feels okay to you? • What could someone say or do to check in before touching you?
Emotional boundaries	• What parts of your life do you like to keep private until trust has been built? • What does it look like when someone respects your feelings?
Material and digital boundaries	• What is something you do not share, such as clothes, money, your phone, passwords, or location? • What would you want someone to ask before posting a photo of you?
Communication boundaries	• How fast is fast enough to reply to a text? • What could you say if you need time before responding?

3B. Practice turning a boundary into language.

Choose one boundary and write a sentence a young person could use to communicate that boundary clearly.

Boundary:

Language to communicate boundary:

Exercise 4: Helping young people practice consent (Slide 28)

Sometimes young people may struggle to figure out how to communicate consent in practice. Use this exercise to help you practice becoming more comfortable talking to young people about communicating consent in their everyday lives.

Purpose	Example language
Ask clearly	• Can I kiss you? • Is this okay? • Do you want to keep going?
Check in	• Do you want to stop or keep going? • How are you feeling about this? • Do you want to slow down?
Decline or slow down	• I am not ready. • Let's slow down. • No, I do not want that. • I changed my mind.
Respect the answer	• Okay. Thanks for telling me. • We can stop. • I do not want you to feel pressured.

Write one consent check-in question you could use to help a young person practice:

Write one respectful response to hearing "no," "not now," or "I changed my mind":

Exercise 5: Healthy relationships in digital spaces (Slide 32)

Technology can support connection, identity exploration, and relationships across distance. It can also create opportunities for pressure, monitoring, harassment, image-based abuse, and other harms. Use this exercise to connect digital behavior back to communication, shared power, boundaries, and consent.

5A. What concerns you, and what concerns young people?

What concerns me as a youth-supporting professional?	What have I heard about that concerns young people?

5B. Connect digital concerns to healthy relationship concepts.

Digital situation	What relationship concept does it connect to?
Someone expects immediate replies and becomes angry when the young person does not respond.	Communication boundaries; shared power; possible monitoring or control
Someone pressures a young person to send a sexual photo.	Consent; boundaries; pressure cancels consent
Someone shares a private image, message, or screenshot without permission.	Consent; trust; privacy; digital boundaries
Someone asks for passwords or location access as proof of trust.	Material/digital boundaries; shared power; potential coercion or surveillance
Someone posts a photo of a young person without asking.	Consent; digital boundaries; respect

Closing reminder

You do not have to solve every relationship issue in one conversation. Your role is to create space, ask good questions, model respect, help young people reflect, and follow appropriate safety protocols when concerns arise.

Acknowledgements

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Conversation Strategies for Talking With Young People About Healthy Relationships

Matthew Rivas-Koehl, Mindy E. Scott, & Dane Rivas-Koehl

Training Script

Slide 1: Conversation Strategies for Talking With Young People About Healthy Relationships

Hello, and thank you for listening to this recorded training on talking with young people about healthy relationships! The training is offered by Activate – the Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-supporting Professionals. My name is Matthew Rivas-Koehl and I am one of the leads at the Activate Center who supports our research-to-practice translation products. I'm joined by my colleague Mindy Scott.

Slide 2: Activate partners with youth-supporting professionals, young people, and researchers to translate research and create...

Hello everybody. I lead the Activate Center and look forward to sharing guidance from a number of Activate's resources focused on having conversations with young people about different aspects of healthy relationships.

I want to start by saying a bit more about the Activate Center.

Activate is led by Child Trends in partnership with Chapin Hall and an external research alliance made up of practitioners, young people, and researchers. We aim to bridge the gap between research and practice. Specifically, we create research-based resources for use by professionals who support young people who experience the child welfare or justice systems, homelessness, or disconnection from school and work (we often call youth who are disconnected "opportunity youth").

The substantive focus of the center is translating research on the sexual and reproductive health of young people in their early teens through early twenties. As I mentioned, we are particularly interested in research that can be used by professionals who work with young people involved in systems, experiencing homelessness, or disconnected from school and work. And we interpret the concept of sexual and reproductive health broadly to include healthy relationships.

Slide 3: Training Goals

Our goal in this training is to keep this information as practitioner-focused as possible, really emphasizing considerations for youth-supporting professionals whenever we can. So we will introduce information about healthy relationships and share some tips about how to apply this information in practice. Then, we are also going to address how some of our information and tips about healthy relationships can apply in digital settings.

As we move through the presentation, you'll see that we introduce concepts, then move to how to apply them. We'll do that for each major concept that we cover.

Slide 4: Handout Exercise 1

Throughout the training, you will see five slides like this one. At each point, we will ask you to pause the training after our cue and turn your attention to the accompanying handout. The handout can be found here. Our handout is meant to be a training tool that can help you follow along and practice some of the skills that we're talking about in the training.

The first exercise is a reflection. We've heard in our work with youth-supporting professionals that having conversations about relationships can be tricky. We'd like you to reflect on why this might be. Pause the training now and answer the accompanying questions for Exercise 1 in the handout.

Slide 5: Healthy Relationships

This slide gives a bit of a road map for key elements of healthy relationships that we are going to cover. On the left, you'll see that we at the Activate Center have emphasized communication, boundaries, and shared power as central to healthy relationships. We've also expanded upon this to explicitly include consent as another key element of healthy relationships. We are going to talk in more detail about each one of these factors. Of course, these are not the *only* elements of healthy relationships, but they are important ones.

I'm now going to hand it over to Mindy to get us started talking about healthy communication.

Slide 6: Healthy Communication: What to Know

Thanks Matthew! Ok, let's talk first about a few things to keep in mind about healthy communication.

Slide 7: What Does Healthy Communication Look Like?

Healthy communication requires several things. First, an essential component is active listening, which is where someone is really paying attention and reflecting back what they heard rather than just waiting for their turn to talk. Second, healthy communication also requires clarity, which means people say what they mean instead of expecting someone to read their mind. For the other person in

the conversation, this might include trying not to make assumptions and using active listening to clearly understand the other person.

Slide 8: What Does Healthy Communication Look Like?

Effective communication also includes elements of emotional regulation, or someone's ability to pause and come back to a conversation rather than react in the moment.

Healthy communication might also include the ability to repair, particularly when things get tough or may have gone wrong in a previous conversation. People misstep; disagreements happen. What matters is whether someone can recognize those missteps, apologize, compromise, and work to rebuild trust.

And finally, healthy communication means that sensitive topics such as sex, boundaries, and trust are handled with respect and empathy rather than pressure, ridicule, or avoidance.

One important point to emphasize with young people is that communication is a life skill. It is something people can practice and improve over time. Additionally, healthy communication is something that can always be modeled, including in your own interactions with young people.

Slide 9: Healthy Communication: Talking With Young people

Now let's shift from defining healthy communication to discussing how to talk about it with young people.

Slide 10: Model Healthy Communication

When you talk with young people about relationships—or really, any time you interact with young people—it's important for you, as the adult, to model healthy communication as you go. Here are some things you can do:

- Ask direct questions so you can better understand what is happening in the young person's relationship instead of guessing.
- Avoid making assumptions about what the young person meant, what they wanted, or how they felt. This is especially important because the same behavior can mean very different things depending on the context.

Active listening is especially useful here. You might say something like, "What I'm hearing is that you felt ignored when that happened. Did I get that right?" That kind of reflection communicates respect, slows the conversation down, and gives the young person a chance to clarify.

When you model these behaviors, this approach also shows young people that conversations about relationships do not have to feel like "interrogations" or awkward interactions. They can be collaborative, thoughtful, and grounded in trying to understand one another.

Slide 11: Handout Exercise 2

One practical way to help young people think about communication is by discussing scenarios. We'd like you to turn to the handout and draw your attention to Exercise 2, where we've provided an example scenario to work though.

The scenario: Jordan tells Kate that she should wear a certain dress to prom. Kate wears the dress even though she does not want to because she is not sure how to discuss the issue with Jordan.

This scenario is useful because it sort of sits in a gray area that warrants some conversation to figure out. On the surface, it may sound small. At the same time, it raises important questions like: Was Kate afraid to disagree? Did she feel pressured? Was this a one-time conflict or part of a broader pattern in the relationship?

Using scenarios like this helps young people practice how to distinguish between healthy and unhealthy dynamics without immediately putting them on the spot to disclose their own experiences. Pause the training now and work through the Exercise 2 activities in the handout.

Slide 12: Shared Power: What to Know

The example of Jordan and Kate gives us a natural segue into the next element of a healthy relationship: shared power.

Communication problems and power imbalances are not the same thing, but they can overlap. Sometimes what looks like a communication issue is really about control. So, when we talk with young people about healthy relationships, it is important to help them think not only about whether people are communicating well with one another, but also about how decisions get made and whose needs, values, and priorities count.

Slide 13: What Does Shared Power Look Like?

Shared power means that people in relationships make decisions together, rather than one person calling all the shots. It means each person's needs matter. In other words, each person should be able to freely express their needs and wants: No one dominates, controls, or punishes the other person in order to get their way.

This does not mean both people always want the exact same thing or that conflict never happens. It is perfectly normal for disagreements to arise and for people to want different things in a relationship. But shared power does mean there is room for both people's voices and preferences. In a relationship with shared power, disagreement does not automatically turn dark with elements of control like pressure, threats, guilt, or retaliation.

Understanding the concept of shared power can be helpful for young people because it shifts the question from "Did we argue?"—the answer to which might be "yes," even in a healthy relationship—

to "How did that decision happen, and did everyone involved really have a say?" That is often a more revealing question.

Slide 14: Shared Power: Talking With Young People

When talking with young people about shared power, it can help to return to a concrete example rather than keep the conversation abstract. Shared power becomes easier to recognize when young people can picture what decision-making, influence, pressure, and choice actually look like in a specific situation.

Slide 15: Listen, Reflect, Explore

Let's revisit the scene with Jordan and Kate. Young people like Kate may come to you to talk about what happened. You might start by listening. You could ask, "What happened?" "How did that make you feel?" or "Did you feel like you had a choice?" Those questions invite the young person to elaborate on the experience and how they felt without leading them toward a particular answer.

Then reflect back what you are hearing. For example, "What I'm hearing is that you felt pressured. Is that right?" Reflection helps young people feel understood and gives them a chance to confirm or correct your interpretation.

Next, explore by probing the situation a bit more. You might ask, "What would shared power in that decision have looked like?" This question helps move from simply naming a problem to imagining a healthier dynamic. It gives young people language not only for what felt off, but for what they might want instead in a relationship.

Notice that, here, we are talking with young people about shared power by using the elements of healthy communication that we just discussed—you can see how there is overlap.

Now I am going to pass it over to Matthew to talk about two more key elements of young people's healthy relationships.

Slide 16: Boundaries: What to Know

Thanks Mindy. I am going to cover the concepts of boundaries and consent. I think shared power transitions nicely to thinking about boundaries. Shared power is partly about whether both people's needs, preferences, and limits matter in a relationship, while boundaries help us make that determination more concrete. They give us language for what feels okay, what does not, and what respect looks like in practice. Discussing boundaries also reminds us that healthy relationships are not just about liking or caring about someone but also about respecting them as their own independent person.

Slide 17: Four Types of Boundaries

Boundaries are personal limits that communicate what someone is and is not comfortable with, including what they choose to share, consent to, or participate in. Boundaries vary by person, but it can be helpful to organize them into four broad categories.

Physical boundaries involve touch, affection, sex, and personal space.

Emotional boundaries involve sharing feelings and privacy around past experiences.

Material boundaries can include those around money, possessions, or access to things like a phone.

And **mental or intellectual boundaries** involve beliefs, opinions, and values.

One useful thing to emphasize with young people is that not everyone will have the same boundaries, and that is okay. A boundary that feels very important to one person may not feel as important to another. What matters is whether those boundaries can be communicated and respected. And notice how this distinction ties back to both communication and shared power!

Slide 18: Boundaries: Talking With Young people

When talking with young people about boundaries, it can help to start in a broad way. Some young people may be more comfortable thinking about boundaries in friendships, family relationships, or daily life before applying those ideas to dating or romantic relationships.

This framing can reduce pressure and help young people engage in some reflection first. Then, once there is more comfort and clarity, you can move toward relationship-specific examples.

This also helps keep the conversation from feeling like a test. The goal is to help young people identify what matters to them and practice putting that into words.

Slide 19: Strategies for Talking With Young People About Boundaries

A practical strategy is to talk about boundaries in general before jumping straight into dating. You might ask about boundaries with friends, roommates, family members, or classmates. That can help young people identify the concept before attaching it to a more personal or emotionally charged context.

It can also be helpful to give young people structured opportunities to reflect. Writing prompts can work well because they allow time to think and do not require personal disclosure. For example, you might ask the young people to reflect and write about, “What are three deal-breakers for you in a relationship?” or “What is one thing you do not share, such as your clothes, your phone, or your location?”

The goal here is not to force disclosure. It is to help young people identify their own limits and begin practicing language for expressing them.

Slide 20: Handout Exercise 3

Let's pause again for a quick exercise. Consider what other questions you could ask to help young people reflect on and talk about their personal boundaries. You might think about questions that help them define what matters to them, imagine what respect looks like, or identify how someone could communicate a boundary clearly. Consider the different types of boundaries as you do this.

Questions can also stay general rather than personal if that feels more appropriate for the young people you work with.

Pause the training now and complete Exercise 3 in your handout.

Slide 21: Consent: What to Know

Now that we have talked about boundaries, let's cover consent. Consent is a clear intersection of communication, power, and boundaries. If boundaries help a person identify their limits, consent is about whether there is clear, voluntary, and informed agreement around what is happening. That's why consent is not just a one-time checkbox: It's an ongoing process grounded in choice, information, communication, and respect.

Slide 22: What Is Consent?

At its core, consent is voluntary, informed, and enthusiastic agreement. Consent is ongoing, which means it can change at any time. A person can agree to something and then decide they do not want to continue. Pressure or fear (or impairment due to substances, for example) can never lead to consent because they undermine a person's ability to choose freely.

Critically, consent can be communicated both verbally and nonverbally, although a combination of both is always best because it reduces ambiguity. And one myth we want to challenge clearly is the idea that the absence of a "no" means "yes." It does not.

Now, even though we often think about consent in the context of romantic relationships and sex, consent is important across contexts and relationships. For example, people can discuss consent in the context of sharing food, looking at someone's phone, or posting pictures of another person.

When talking with young people, it can be helpful to keep bringing consent back to real questions like, "Was there a choice?" "Was the person informed?" "Was there pressure?" "Could they change their mind?" To connect back to other elements of healthy relationships, we can use a question like, "Were that person's boundaries understood and respected?"

Slide 23: Consent: Talking With Young People

When we move into talking with young people about consent, examples matter. Consent can feel abstract until young people hear what it actually sounds like in practice. Because we've already

talked about boundaries, you can frame consent as a way for people to actively communicate and honor those boundaries in real time.

Slide 24: Ways Young People Communicate Consent

This slide provides concrete examples of how young people might communicate consent. As you can see, there isn't just one perfect phrase or way to ask, and both verbal and nonverbal cues matter. No matter what, consent should involve a clear ask, clear check-ins, and/or clear responses.

Examples of asking for consent might include questions like, “Can I kiss you?” or “Is this okay?” Examples of checking in might sound like, “Do you want to keep going?” or “Want to stop or keep going?” And examples of declining or slowing down might sound like, “I’m not ready,” “Let’s slow down,” or “No, I don’t want that.”

For youth-supporting professionals, these examples can be useful because they make the conversation specific. They give young people language they can recognize, practice, and use. You can find this visual and more tips in our consent TA tool linked here too!

Slide 25: Handout Exercise 4

Even if young people have a solid understanding of what consent is and why it is important, they may still feel uncomfortable communicating consent, or struggle with how to bring it up. Exercise 4 in your handout is meant to help you as a youth-supporting professional become more comfortable with helping young people practice consent. Pause the training now and complete Exercise 4 in your handout.

Slide 26: Healthy Relationships and Technology: What to Know

We’ve now covered several key concepts of healthy relationships. In this final section, we want to briefly address how these concepts can play out (or not) online.

Slide 27: Technology and Relationships - Risks and Opportunities

Using technology to communicate, such as texting, DMs, social media, and video calls, are important ways that young people communicate and connect with one another. This can be particularly true for young people who have more trouble doing so in-person. (This goes back to that communication piece of healthy relationships we discussed.) For example, technology can help young people stay in touch, explore their identities, and maintain relationships across distances. But, in some cases, it can also expose them to harm.

The point here is not to debate whether technology is good or bad, but to be aware that healthy and unhealthy relationship dynamics—including those related to communication, power, boundaries, and consent—can occur online as well.

It is useful for youth-supporting professionals to stay aware of the digital contexts young people navigate—including current platforms, norms, and trends—because these contexts shape how relationship dynamics are experienced and interpreted. On the next slide, we will dive more into cyberbullying and what to watch for with that. I also want to highlight that experts are increasingly concerned about mis- and disinformation online: This goes for both young people *and* the rest of us too. We all might receive information that influences our ideas about how technology influences relationships, and it's important to question the motives behind that information and its source. In other words, I am reminding us all of something we might have heard many times: You can't trust everything you see online!

Slide 28: Sexual Cyberbullying: What Is It?

Sexual cyberbullying, which refers to a wide range of behaviors, is defined as any sexually aggressive or coercive behavior facilitated by electronic media. These actions are intended to harm, embarrass, threaten, or intimidate another person. The terms used for specific behaviors may overlap and are not always used consistently.

Sexual cyberbullying may have a detrimental effect on young people who have prior experiences with trauma, unstable living arrangements, and/or a lack of supportive adults in their lives. Furthermore, some of these young people may rely on digital platforms to stay connected with family and friends from whom they have been separated, increasing their risk for being a victim of sexual cyberbullying. However, sexual cyberbullying can happen to any youth, not just those who have experienced trauma or instability. It is important to be prepared to help all youth navigate relationships in a digital context.

For youth-supporting professionals, part of the work is helping young people recognize that harmful behaviors online represent harmful behaviors in their relationships. Connecting these behaviors back to other concepts we've discussed, consider how some of these experiences are clear indications of boundaries being violated or an imbalance of power in a relationship. In a minute, we'll talk through these types of harm in more detail. Pause here and take time to read through each definition. You can do this out loud if you are viewing in a group setting.

Slide 29: Sexual Cyberbullying Behaviors

All of these relationship concepts are at play when we think about sexual cyberbullying. Examples of sexual cyberbullying include sextortion, where someone is coerced into providing sexual images or favors under threat—this type of behavior connects directly to the idea of boundaries and what it looks like to violate boundaries, maybe resulting from power one has over another

Online sexual harassment involves sending unwelcome sexual messages or engaging in inappropriate behavior in digital spaces. This also relates to boundaries.

Nonconsensual sexting occurs when private, explicit images or messages are shared without consent, tying directly to consent and to healthy communication and boundaries.

Slide 30: Sexual Cyberbullying Behaviors

Revenge porn involves sharing intimate images or videos of someone to humiliate or harm them, often after a breakup: In this scenario, boundaries are violated, trust is broken, and no consent is present.

Cyberstalking refers to persistent and unwanted online monitoring, harassment, or threats.

Cyberdating abuse includes manipulative or abusive behaviors in online relationships, such as controlling someone's actions or spreading harmful content—definitely connecting back to shared power.

We provide these as examples of some behaviors or experiences that you might want to watch out for in terms of harm that can occur online, and how they connect back to healthy relationships.

Slide 31: Healthy Relationships and Technology: Talking With Young People

So how do we actually talk with young people about healthy relationships in digital spaces?

A useful starting point is to remember that many young people already understand the platforms they are using very well. What they may need help with is thinking through what healthy communication, consent, privacy, and boundaries mean within those platforms: That's where you can come in.

Slide 32: Helping Young People Think About Healthy Relationships in a Digital World

We can help young people think about what healthy relationships and boundaries mean in the digital world.

This slide offers a few concrete ways to start those conversations. You might ask, "How do you and your partner use social media in your relationship?" "How fast is fast enough to reply to a message or text?" or "What would you do if someone pressured you to send a photo you did not want to send?" These questions invite young people to think about expectations, pressure, and digital norms without assuming a problem.

It is also helpful to give examples of digital boundaries. A young person might say, "I'm not sharing my password," "I'm busy. I'll reply when I can," or "Don't post me without asking." These and other examples make it easier to connect healthy relationships to online behavior.

Finally, encourage young people to look for accurate, evidence-informed information. Inaccurate or misleading messages about relationships are easy to find online, so source-checking matters.

Slide 33: Handout Exercise 5

You're almost to the end of the training and this is our last exercise in the handout. Now that we've introduced the digital context, reviewed several forms of sexual cyberbullying, and discussed strategies for talking with young people, pause the training and complete Exercise 5 in the handout.

After that, I am going to pass it over to Mindy to wrap us up.

Slide 34: Final Considerations

As we begin to wrap up, we want to leave you with just a few final considerations that can guide your practice across all of these topics.

Slide 35: Final Considerations

These reminders are meant to bring us back to the role of youth-supporting professionals like you all. You do not have to solve every relationship issue in one conversation. What matters is creating space for reflection, respect, and safer decision-making.

Guide young people toward making healthy relationship decisions but respect their autonomy by not telling them how to feel or what to do.

Meet young people where they are. Young people may vary with respect to their understanding of healthy relationships, their relationship experiences, and their capacity to consider new information.

You do not need to have all the answers; your role is to create space, ask good questions, model respect, and help young people reflect on what healthy relationships look and feel like in their lives.

Slide 36: Stay Informed!

Thank you for taking time to participate in this training. If you would like to learn more about Activate or any of the resources mentioned in this presentation, please visit our website or LinkedIn page.

Related Research and Resources

Citation	Informed Content on Slides:
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Rosenberg, R., Rivas-Koehl, M., Mihalec-Adkins, B., Schlecht, C., Parekh, J., & Rivas-Koehl, D. (2025a). *A practice guide for understanding consent*. Child Trends.	5-19
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Schlecht, C., Griffin, A. M., & Rosenberg, R. (2024a). *How to decode signs of sexual cyberbullying and support teens and youth*. Child Trends. Schlecht, C., Griffin, A. M., & Rosenberg, R. (2024b). *Sexual cyberbullying research summary*. Child Trends.	27-32

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Module 3: Violence Prevention and Intervention

What's Inside? Resources offer research-informed guidance for professionals working with young people at risk for experiencing workplace sex-based harassment, sex trafficking, and intimate partner violence.

Contents

Research on sex trafficking and intimate partner violence

- Definitions
- Prevalence
- Warning signs and risk factors
- Connections to system involvement and homelessness

Workplace harassment

- Defining sex-based harassment
- Identifying workplace risk factors
- Prevention and intervention strategies

Practical tools

- Conversation starters
- Screening and assessment tools
- Evidence-based programs and supports
- Resource directories and hotlines

Module 3 Navigation Matrix

Violence Prevention and Intervention

This matrix provides an at-a-glance overview of the resources in Module 3. Use it to quickly identify each type of resource, overlap with other module topics, and the population(s) of young people emphasized. Click a resource title below to jump directly to that resource!

Resource Title	Topic Overlap:		Young People Experiencing...
A Research-Based Question and Answer Resource on Sex Trafficking for Youth-Supporting Professionals	✓	✓	✓ Child Welfare System ✓ Justice System ✓ Homelessness ✓ Disconnection
How to Start a Conversation With a Young Person Who May Be a Sex Trafficking Survivor	✓	✓	
A Research-Based Question and Answer Resource on Intimate Partner and Teen Dating Violence for Youth-Supporting Professionals	✓	✓	✓ Child Welfare System ✓ Justice System ✓ Disconnection
How to Start a Conversation With a Young Person Who May Be Experiencing Intimate Partner Violence or Teen Dating Violence	✓		
Opportunity Youth and Sex-based Harassment in the Workplace: A Scan of Research and Resources	✓		✓ Disconnection

Resource Types: Research Summary | Conversation Support | Q&A Resource

Topics: Healthy Relationships | Violence Prevention & Intervention | Pregnancy & Parenting | Sexual & Reproductive Health Care

A Research-Based Question and Answer Resource on Sex Trafficking for Youth-Supporting Professionals

Colleen Schlecht, Amanda M. Griffin, & Melissa Kull

Sex trafficking is of growing concern to professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. Sex trafficking survivors (i.e., those who are currently being trafficked or who were trafficked in the past) may suffer a variety of short- and long-term physical and psychological consequences including sexually transmitted infections, unintended pregnancy, depression, post-traumatic stress disorder, substance abuse, malnutrition, and suicidality. These consequences can disrupt normative development and persist into adulthood.[1, 2]

This resource provides answers to common questions that youth-supporting professionals may have about sex trafficking. Some of these questions may be of interest to all youth-supporting professionals, regardless of the young people with whom they work. Other questions may be of particular interest to youth-supporting professionals who work with young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work.

- What is sex trafficking?
- What are the signs a young person may be a sex trafficking survivor?
- How can you start a conversation with a young person who may be a sex trafficking survivor?
- What sex trafficking screening and assessment tools have been developed for use with young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?
- What resources related to sex trafficking are available to young people who are sex trafficking survivors or youth-supporting professionals?
- How prevalent is sex trafficking among young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?
- What are the links between sex trafficking and child welfare system involvement, justice system involvement, and experiencing homelessness?
- What evidence-based programs are available to help young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school who are at risk for or survivors of sex trafficking?

Activate: The Collective to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals aims to bridge the gap between research and practice in support of the Office of Population Affairs' mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating research- based resources for use by professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from work and school (i.e., opportunity youth).

ACTIVATE

By providing research-based answers to these questions, this resource can help professionals appropriately respond to the needs of young people who experience with the child welfare and/or justice systems, homelessness, and/or disconnection from school and work who are at risk for or survivors of sex trafficking.

What is sex trafficking?

Sex trafficking is the crime of using force, fraud, or coercion to induce another individual to do a commercial sex act as defined by the Trafficking Victims Protection Act of 2000 (TVPA).[3] Common types include escort services, pornography, illicit massage businesses, brothels, and outdoor solicitation. Under TVPA, any commercial sexual activity with a young person under age 18, even without force, fraud, or coercion, is considered trafficking.[4] Sex trafficking of a minor is also referred to as the commercial sexual exploitation of children.

What are the signs that a young person may be a sex trafficking survivor?

A young person may be a sex trafficking survivor if they:[5]

- Want to stop participating in commercial sex but feel scared or unable to.
- Disclose that someone pressured them to engage in commercial sex.
- Live where they work or are transported by guards between home and their workplace.
- Live with or are dependent on a family member who is abusive or has a substance use problem.
- Have a "pimp" or "manager" in the commercial sex industry.
- Work in an industry where it may be common to be pressured into performing sex acts for money, such as a strip club, go-go bar, or an illicit cantina or massage business.
- Have a controlling parent, guardian, romantic partner, or "sponsor" who will not allow them to meet or speak with anyone alone or who monitors their movements, spending, or communications.

Importantly, any commercial sexual activity with a young person under age 18, even without force, fraud, or coercion, is considered sex trafficking.

How can you start a conversation with a young person who may be a sex trafficking survivor?

Before starting a conversation with a young person about sex trafficking, first ask yourself the following:

- Does the young person appear to be in crisis (e.g., threatening to harm themselves or others, unable to control their emotions or behaviors, under the influence of alcohol or other drugs)?
- Are you somewhere young people feel safe?
- Can you maintain confidentiality?
- Have you built enough rapport with the young person to ask sensitive questions?
- Do you know enough information about the young person to ask questions that are sensitive to their history of trauma or other adverse experiences?
- Do you believe you are the best person in your organization to have this conversation with the young person?

Following are some questions you can ask young people to determine if they are a sex trafficking survivor:[6]

- Are your communications (e.g., calls, emails, texts, chats, conversations) ever restricted or monitored?
- How do you get by day-to-day if you are living on the streets?
- Has anyone offered you something like food or a place to sleep in exchange for sexual favors?

New York State's Office of Children and Family Services has developed several child trafficking resources to facilitate conversations with young people about sex trafficking, including Do's and Don'ts When Discussing Child Trafficking with survivors and Engaging in Conversations with Potential Survivors.

Between **15% and 40%** of young people experiencing homelessness report being a survivor of sex trafficking.

What sex trafficking screening and assessment tools can be used with young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?

The following sex trafficking screening and assessment tools have been validated with young people involved with the child welfare system or experiencing homelessness.

The Human Trafficking Screening Tool for youth involved with the child welfare system, youth who have run away, and youth experiencing homelessness was developed and tested by the Urban Institute.[26]

New York's Office of Child and Family Services (OCFS) requires the completion of a rapid indicator tool on behalf of all young people under age 18 who are under the care or supervision of a county Department of Social Services or OCFS to determine whether they are at risk for or a survivor of sex trafficking. A Spanish language version is also available.[27]

The Human Trafficking Interview and Assessment Measure (HTIAM-14) is a human trafficking screening tool validated for use with 18 to 22 year-olds experiencing homelessness.[28] It can take up to 45 minutes to administer and requires an interviewer with human trafficking expertise.

The Quick Youth Indicators of Trafficking (QYIT) is a sensitive, brief, and user-friendly trafficking screening tool developed by Covenant House that is validated for use with homeless young adults.[29]

The Trafficking Victims Identification Tool (TVIT) is a 30-item validated screening tool for identifying human trafficking survivors developed by the Vera Institute.[30,31]

What resources related to sex trafficking are available to young people who are sex trafficking survivors or youth-supporting professionals ?

If you are working with a young person who you believe is a sex trafficking survivor, share the 24-hour National Human Trafficking Hotline that connects sex and labor trafficking survivors with services and supports.

- Phone number: 1-888-373-7888
- Text option (message and data rates may apply): Text 233733
- Live chat function: www.humantraffickinghotline.org/chat
- Submit a tip online using the anonymous online reporting form: https:// humantraffickinghotline.org/report-trafficking

The following organizations provide additional sex trafficking resources and trainings:

- *Futures Without Violence*: Empowers individuals and organizations working to end violence against women and children around the world through programs, policies, and campaigns. For more information visit: www.futureswithoutviolence.org
- *Polaris*: Serves as a data hub for the anti-human trafficking field to support the social justice movement to fight sex and labor trafficking. For more information visit: https://polarisproject.org/human-trafficking/

- *Human Trafficking Search*: Global resource and research database on human trafficking. For more information visit: https://humantraffickingsearch.org/traffickingresources
- *Darkness to Light*: Offers a single session online training about the root cause of commercial sexual exploitation of young people under age 18 and why preventing sexual abuse is important for reducing the risk that young people will be sex trafficked. For more information visit: https://www.d2l.org/education/additional-training/child-exploitation/

How prevalent is sex trafficking among young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?

Estimates of the prevalence of sex trafficking among young people in the U.S. are not available.[7] Although several studies have examined the prevalence of sex trafficking among samples of young people experiencing homelessness, these samples are typically small and not representative of the homeless youth population.

Between 15% and 40% of young people experiencing homelessness report being a survivor of sex trafficking.[8-12]

Many young people experiencing homelessness who have been sex trafficked were first sex trafficked when they were under age 18. Depending on the study, between 36% and 86% of young people experiencing homelessness who were sex trafficked were under age 18 the first time they were trafficked.[9,11] A study of young people seeking services for homelessness in 10 U.S. and Canadian cities found that 50% of those who identified as survivors of sex trafficking were under age 16 the first time they were trafficked.[12]

What are the links between sex trafficking and child welfare system involvement, justice system involvement, and experiencing homelessness?

Sex traffickers strategically target young people in foster care because their trauma histories coupled with the child welfare system's failure to provide a sense of belonging leave them vulnerable to exploitation.[7,13-15] Sex traffickers also know where group homes are located and seek out young people in those placements, using cell phones first to entice them and then to control and track their whereabouts.

Young people in foster care, especially those in congregate care, often run away from their placements, which puts them at risk for sex trafficking. Some young people who run away end up on the street where they may be exploited by sex traffickers or recruited into sex trafficking by other young people who are being sex trafficked. They may also resort to "survival sex" to meet their basic needs.[10,17]

Sex trafficking can lead to justice system involvement among young people. Historically, minors involved in the sex trade were criminalized by the justice system for prostitution and related offenses such as running away. Despite efforts by child advocates to shift the response to sex trafficking from punitive to restorative, sex trafficking survivors continue to be detained and incarcerated for offenses related to their sexual exploitation.[18]

Young people experiencing homelessness are at heightened risk for commercial sexual exploitation and sex trafficking. Many young people who are homeless resort to "survival sex" to meet their basic needs for shelter, food, and other essentials. Additionally, homelessness among young people often is a result of other risk factors for commercial sexual exploitation and sex trafficking such as poverty, family dysfunction,[19] and a history of neglect, abuse, or other trauma.

What evidence-based programs are available to help young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school who are at risk for or a survivor of sex trafficking?

The Runaway Intervention Program (RIP) is an intensive home visiting and case management program that promotes the healthy development of 12 to 15 year-old girls who have run away and have been sexually assaulted or exploited. After an initial assessment, advanced practice nurses provide case management, healthcare, and health education at home and in school. Studies have found that RIP reduces risk behaviors, increases self-esteem, and helps runaway youth who identified as females reconnect to school and family.[20-22] For more information visit: https://cdc.thehcn.net/promisepractice/index/view?pid=3600

Peer Education and Connection through Empowerment (P.E.A.C.E.) is a three-month, group- based, trauma-informed and peer-supported psychosocial intervention for 16 to 24 year-old girls who have experienced homelessness and sex-based violence, including sexual exploitation or trafficking. Group activities focus on health promotion and include psychoeducational sessions facilitated by a health promotion coordinator and two peer mentors. Evaluations of PEACE have found improvements in quality of life and reductions in experiences of victimization among participants 12 months post-enrollment,[23] as well as satisfaction with the intervention.[24] For more information visit: http://kh-cdc.ca/en/project-profiles/peace.html

One study found that **50%** of sex trafficking survivors seeking services for homelessness were under age 16 the first time they were trafficked.

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How to Start a Conversation With a Young Person Who May Be a Sex Trafficking Survivor

Before starting a conversation with a young person about sex trafficking, first ask yourself the following:

- Does the young person appear to be in crisis?
- Are you somewhere young people feel safe?
- Can you maintain confidentiality?
- Have you built enough rapport with the young person to ask sensitive questions?
- Do you know enough information about the young person to ask questions that are sensitive to their history of trauma or other adverse experiences?
- Do you believe you are the best person in your organization to have this conversation with the young person?

Here are some questions you can ask young people to determine if they are a sex trafficking survivor:

- Are your communications (e.g., calls, emails, texts, chats, conversations) ever restricted or monitored?
- How do you get by day-to-day?
- Has anyone offered you something like food or a place to sleep in exchange for sexual favors?

If you are working with a young person you believe is a sex trafficking survivor, share the 24-hour National Human Trafficking Hotline.
www.humantraffickinghotline.org

Visit activatecollective.org for more information.

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A Research-Based Question and Answer Resource on Intimate Partner and Teen Dating Violence for Youth-Supporting Professionals

Melissa Kull, Colleen Schlecht, & Amanda M. Griffin

Intimate partner violence (IPV) and teen dating violence (TDV) are of growing concern to professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. IPV/TDV have been linked to negative sexual and reproductive health outcomes among young people who experience the child welfare and/or justice systems and/or homelessness, including a lower likelihood of frequent condom use, unplanned pregnancy, and engaging in sex under the influence of alcohol and drugs. [1-3]

This resource provides answers to common questions that youth-supporting professionals may have about IPV and TDV. Some of the questions may be of interest to all youth-supporting professionals, regardless of the young people with whom they work. Other questions may be of greater interest to youth-supporting professionals who work with young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work.

- What are IPV and TDV?
- What are the signs that a young person may be experiencing IPV/TDV?
- How can you start a conversation with a young person who may be experiencing IPV/TDV?
- What supports are available to young people experiencing IPV/TDV?
- What is the prevalence of IPV/TDV among young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?
- What evidence-based programs are available to help young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school who are at risk for or experiencing IPV/TDV?

By providing research-based answers to these questions, this resource can help professionals appropriately respond to the needs of young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work who are experiencing or at risk for IPV/TDV.

Activate: The Collective to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals aims to bridge the gap between research and practice in support of the Office of Population Affairs' mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating research- based resources for use by professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

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What Are Intimate Partner Violence (IPV) and Teen Dating Violence (TDV)?

Intimate Partner Violence (IPV) is any abuse between romantic partners who may or may not be living together.[4] Teen dating violence (TDV) is IPV that occurs within the context of a dating relationship in which the partners are under age 18.

IPV can take different forms, including:[5,6]

- Physical violence: Hurting or trying to hurt a partner using physical force. This includes hitting, shaking, kicking, pushing, biting, throwing objects, using a weapon, and strangulation.
- Sexual violence: Forcing or attempting to force a partner to take part in a sex act or sexual touching when the partner does not or cannot consent; posting or sharing sexual pictures of a partner without their consent; or sexting someone without their consent.
- Psychological aggression: Using verbal and non-verbal communication with the intent to mentally or emotionally harm or exert control over a partner.
- Stalking: Pattern of repeated, unwanted attention and contact by a current or former partner that causes fear or safety concerns.

What are signs that a young person may be experiencing IPV/TDV?

Young people may be in unhealthy or abusive relationships if they:[7]

- Report that their partner is intensely jealous or possessive.
- Become depressed, moody, or argumentative.
- Frequently check in with their partner.
- Have unexplained bruises, scratches, or burns on their body.
- Report symptoms (e.g., sore throat, headaches, or dizziness) that could be caused by strangulation.[8]
- Defer to the partner's every wish.
- Often apologize for their partner's behavior.
- Experience a change in academic performance.
- Are isolated from friends and family.
- Get visibly upset after phone calls or dates with their dating partner.

In studies of young people currently or formerly in foster care, 16% to 62% of young women and 20% to 31% of young men report being a victim of IPV/TDV.

- Are afraid of making their partner angry.
- Describe being “punished” by their partner through silence, humiliation, or force.
- Lose interest in activities.

How do you start a conversation with a young person who may be experiencing IPV/TDV?

These prompts are ways to start a conversation with a young person who may be experiencing IPV/TDV.[9, 10]

1. Explain that a healthy relationship is one in which their partner cares about their happiness, understands that they have friends and a life outside of the relationship, does not pressure them to do anything, and values their privacy. Then express concern that they may not be in a healthy relationship.
2. Ask the young person if their partner ever…
    a. Tries to stop them from seeing or talking to family or friends.
    b. Calls them derogatory names, puts them down, or criticizes them.
    c. Threatens or scares them.
    d. Hits, slaps, pushes, or kicks them.
    e. Pressures or forces them to do something sexual when they don’t want to.
    f. Humiliates them when they are alone or in front of others.
    g. Controls where they go, what they wear, or what they do.
    h. Gives them the silent treatment for not doing what they wanted.
3. Give the young person time and tools.
    a. Encourage them to think about their relationship.
    b. Assure them that you will be there for them if they want to talk.
    c. Encourage them to talk with someone else if they are not comfortable talking with you.
    d. Share resources that they might find helpful.

What supports are available to young people experiencing IPV/TDV?

If you believe a young person is experiencing IPV, share the National Domestic Violence Hotline, a 24-hour confidential service for survivors, victims, and those affected by domestic violence, intimate partner violence, and relationship abuse.

- Phone number: 1-800-799-SAFE (7233)
- Text option (message and data rates may apply): Text “START” to 88788
- Live chat function: https://www.thehotline.org/

If you believe a young person is experiencing TDV, share the National Teen Dating Abuse helpline, a 24-hour helpline for teens (ages 13-18) experiencing dating abuse.

- Phone number: 866-331-9474
- Text option (message and data rates may apply): Text "LOVEIS" to 22522
- Live chat function: https://www.loveisrespect.org/

How prevalent are IPV and TDV among young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school?

Research indicates that between 10% and 30% of young people in the general population experience IPV or TDV, with rates varying for males and females.[9-11] Studies of IPV/TDV among young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school find similar rates, although rates are often based on small, nonrepresentative samples.

Studies of young people currently or formerly in foster care have found that 16% to 62% of young women and 20% to 31% of young men have been a victim of IPV/TDV.[2,12-13] One of these studies also found that 30% of females with a history of child welfare system involvement had experienced reproductive coercion (e.g., partners telling them not to use birth control, taking a condom off during sex, or forcing them to have sex without using a condom).[12]

Sixteen percent of first-time, court-involved non-incarcerated females in a longitudinal study reported being the victims of physical dating violence, and court-involved males were as likely as court-involved females to report being victimized.[14, 15]

Between one-fifth and one-third of the young people seeking drop-in services in Los Angeles reported being a victim of IPV.[16, 17] In one study, 25% of the females and 22% of the males reported being the victim of IPV during the past year.[16] In the other study, 31% of the young people who had been in a sexual relationship within the past year reported being a victim of IPV within the context of their most recent relationship.[17]

The only published study of IPV/TDV among young people disconnected from work and school found that 14% of young Black females enrolled in an employment training program reported being the victim of TDV.[18] Data from the National Survey of Family Growth indicate that 13% of females and 7% of males who were disconnected from school and work had ever been forced to have sex by a male dating partner.[19]

What evidence-based programs are available to help young people at risk for or experiencing IPV or TDV?

Two evidence-based IPV/TDV prevention programs have been used with young people involved with the child welfare and/or justice system. We could not find documentation of these or similar programs being used with young people experiencing homelessness or disconnected from work and school in peer-reviewed or gray literature.

Break the Cycle's Ending Violence is a 3-day teen dating violence prevention curriculum designed for middle and high school students. Teens learn about preventing and safely ending abusive relationships; their legal rights and responsibilities; and building healthy relationships. Schools, community-based organizations, and juvenile detention facilities have used the curriculum.[20]
https://www.violencepreventionworks.org/public/ending_violence.page

The Youth Relationships Project is an 18-session teen dating violence prevention program for 14 to 16 year-olds with a history of child maltreatment. This program aims to increase awareness about the signs of an abusive relationship and teach youth how to develop healthy relationships with dating partners. Youth learn about abuse and power dynamics in relationships, develop skills to avoid abusive relationship and resolve conflicts in non-violent ways, and become familiar with community resources from which they can seek help if they experience dating violence.[21, 22]
https://crimesolutions.ojp.gov/ratedprograms/467

Between **one-fifth** and **one-third** of the young people seeking drop-in services in Los Angeles reported being a victim of IPV.

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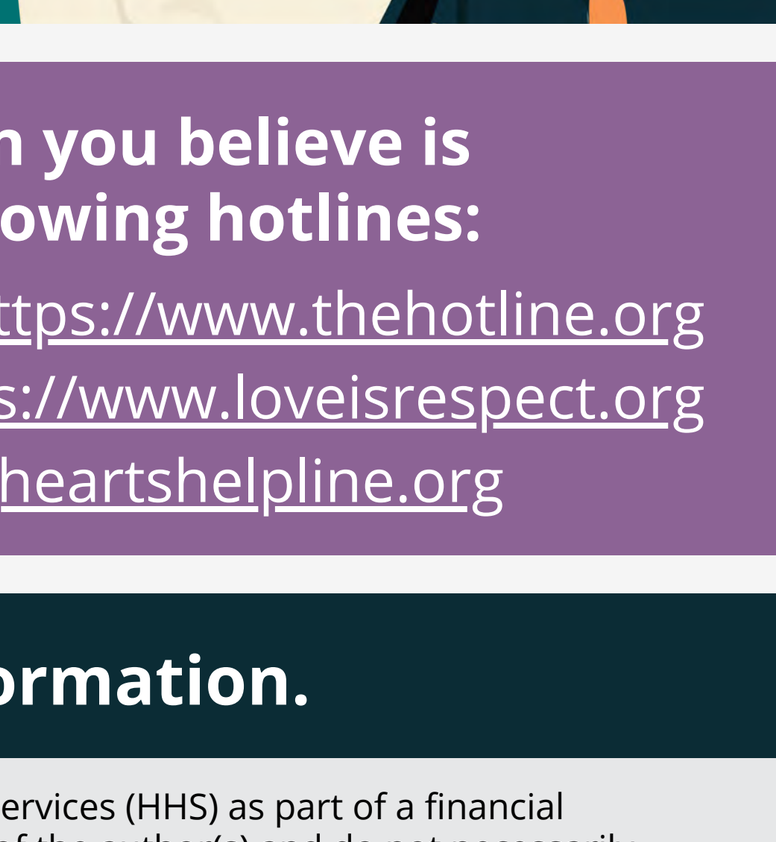
How to Start a Conversation With a Young Person Who May Be Experiencing Intimate Partner Violence or Teen Dating Violence

Ask the young person if their partner has ever

- Tried to stop them from seeing or talking to family or friends.
- Calls them derogatory names, puts them down, or criticizes them.
- Threatens or scares them.
- Pressures or forces them to do something sexual when they don't want to.
- Physically hurts them.
- Humiliates them when they are alone or in front of others.
- Controls them.
- Gives them the silent treatment for not doing what they want.

Give the young person time and tools.

- Explain that a healthy relationship is one in which their partner cares about their happiness.
- Express concern that they may not be in a healthy relationship.
- Encourage them to think about their relationship.
- Assure them that you will be there if they want to talk and encourage them to talk with someone else if they are not comfortable talking with you.
- Share resources that might be helpful.



If you are working with a young person you believe is experiencing IPV or TDV, share the following hotlines:

- The National Domestic Violence Hotline: https://www.thehotline.org
- National Teen Dating Abuse Helpline: https://www.loveisrespect.org
- StrongHearts Native Helpline: www.strongheartshelpline.org

Visit activatecollective.org for more information.

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Opportunity Youth and Sex-based Harassment in the Workplace: A Scan of Research and Resources

Sam Beckwith, Colleen Schlecht, Katelyn Rust, Nia-Simone Woods, Hannah Lantos, and Jan DeCoursey

Opportunity youth, or young people ages 16 to 24 who are not currently connected to school or work, tend to work in sectors and environments that put them at a greater risk of sex-based harassment/victimization.

Sex-based harassment is a form of sexual discrimination—or unfavorable treatment based on an employee's sex—and it is illegal and unacceptable. It is a complex problem that can take multiple forms and may not be recognized or reported by workers. It is also extremely common; each year, sex-based harassment is formally reported more than 10,000 times, and it is likely that a muchlarger proportion of workers experience it but do not report their experience.[1,2]

Youth-supporting professionals are critical resources to the young people they serve, but when it comes to workplace sex- based harassment, they may feel there is not much they can do to intervene. While it is true that youth-supporting professionals may not be able to fully prevent harassment from occurring, they can tailor services and supports to help protect youth—and to help youth protect themselves—by recognizing harassing behaviors and navigating how to address harassment if it does take place.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Understanding sex-based harassment is an important tool for youth-supporting professionals and can empower opportunity youth as they navigate the workplace. This resource describes how youth- supporting professionals can aid youth by:

- Becoming familiar with the topic of sex-based harassment
- Recognizing elements of employer and workplace environments that enable or prevent harassment
- Monitoring youths' experiences
- Being sources of stability and support

Navigating this resource

Why focus on sex-based harassment and opportunity youth? 2
Methods 2
What is sex-based harassment? 3
What should youth-supporting professionals know about sex-based harassment in the workplace? 5
What can youth-supporting professionals do to prevent and address sex-based harassment? 7
Appendices 9
Methods Note 12
References 16

Why focus on sex-based harassment and opportunity youth?

As with other forms of workplace violence, sex-based harassment is largely shaped by an individual's field of work, the provisions of their employment, and/or their perceived consequences of reporting the harassment. Opportunity youth need support to understand and address sex-based harassment. Unfortunately, opportunity youth may be at particular risk of harassment when (re)joining the workforce, and the consequences of harassment may be detrimental to their future work experiences. Some of the highest-risk industries for harassment—such as hospitality, service, retail, and construction—are also industries that frequently employ young people. They are some of the most common industries in which opportunity youth are most likely to have early employment experiences as they prepare to (re)join the workforce. Because sex-based harassment is often perpetrated by those with more power in the workplace against those with less power, harassers may perceive opportunity youth as potential targets for victimization. Additionally, the personal and career impacts of experiencing sex-based harassment could be especially damaging to opportunity youth because of factors such as limited work experience, fewer perceived job alternatives, and past histories of trauma and potential for re-traumatization, among others. As with other vulnerable youth populations,[3] opportunity youth may also face greater risk of being targeted for sex trafficking (for more information on sex trafficking, read Activate's A Research-Based Question and Answer Resource on Sex Trafficking for Youth-Supporting Professionals).

Methods

We conducted a multi-step scoping review of peer-reviewed and grey literature that focuses on elements of sex-based harassment most relevant for opportunity youth, including the following:

1. Individual and group discussions to identify a set of relevant concepts with eight youth-supporting professionals, six current or former opportunity youth, and five subject matter experts
2. Initial searches of recent (2010-2023) peer-reviewed literature using search terms related to sex-based harassment and opportunity youth (see Methods Note)
3. Search of non-peer-reviewed literature ("grey literature") across relevant organizations and initiatives
4. Consultations with seven project advisors (six youth-supporting professionals and one former opportunity youth) to present initial findings and identify next directions for the search
5. Supplementary targeted searches on topics resulting from consultations with advisors
6. Feedback from final reviews from project advisors (three youth-supporting professionals) on content and structure

We scanned research and resources ("sources") for relevance and—if deemed relevant—added them to a database that tracked sources based on their type (e.g., peer-reviewed article, report, toolkit), population of interest, and content. Across 40 years of U.S.-based research on sex-based harassment reviewed for this resource, opportunity youth were never the focal population. For this reason, we considered sources that focus on other populations such as young workers, workers in specific industries, and other workers at risk of experiencing sex-based harassment. The review prioritized sources that were recent (published after 2010) and focused on the United States, although exceptions were made for sources that contributed unique or highly relevant information in other ways. In total, 150 relevant sources were reviewed during the production of this resource. More information about the literature search methods is included in the Methods Note.

What is sex-based harassment?

The following section defines and identifies types of sex-based harassment in the workplace and reviews what is known about the prevalence of sex-based harassment at work.

What is the definition of sex-based harassment?

Sex-based harassment is a form of sexual discrimination, or unfavorable treatment based on an employee's sex.

Sex-based harassment is legally defined as:

- Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature
- Submission to or rejection of this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment (CFR)

In other words, the definition categorizes any unwanted sexual behavior or insinuation in which the victim's display of (dis)engagement could possibly impact their employment, performance, or comfort in the workplace.[4] In this resource, the broader term "sex-based harassment" is used instead of the more common term "sexual harassment," because it captures harassment that is sexual in nature, as well as that which is based on one's sex.

Not all sex-based harassment looks the same. Sex-based harassment can take many forms, some of which young people may not recognize as harassment. Examples of sex-based harassment include (but are not limited to) sexual jokes, sexual photos, touching, requests for sexual favors, and sexual and non-sexual conduct based on one's sex. More specifically, this can include suggestive name calling or comments that associate one's perceived skill or ability with their sex.

Sex-based harassment can happen to anyone. Anyone can become a victim of sex-based harassment, regardless of characteristics such as their sex, sexual orientation, race or ethnicity, relationship status or history, socioeconomic background, workplace, or role. If someone is the victim of harassment, it is never their fault. This resource will describe how some groups of workers, including opportunity youth, may face particular risk of experiencing sex-based harassment.

What are the different types of sex-based harassment?

Employees, including young employees, may face multiple forms of sex- based harassment.

These forms include:

1. **Quid pro quo:** An instance in which a person in a position of power demands the performance of a sexual favor from an employee in exchange for an employment- related action or benefit.[5]
2. **Hostile work environment:** Sexual and sex-related workplace harassment or actions that create an intimidating, hostile, or offensive work environment or contribute to an interference in employee work performance.[6]
3. **Harassment by non-employees:** Sexual and sex-related workplace harassment that is perpetrated by someone other than an employee, such as a client, customer, or vendor.[7]

Appendix 1: Sex-based Harassment Types and Explanations describes these three harassment types in more detail and provides sample language for communicating about them in a youth-friendly way.

Any form of sex-based harassment in the workplace is discrimination, illegal, and never okay. Workers in the United States have legal rights, protections, and recourses against workplace sex-based harassment at the national, state, and local levels. Several major federal laws, policies, and regulatory entities aim to protect employees from sex-based harassment in the workplace. The most prominent of these are Title VII, the Equal Employment Opportunity Commission (EEOC), and Title IX. Meanwhile, specific protections offered by state laws vary.

Sex-based harassment may be sexual or non-sexual. Certain types of sex-based harassment—namely, quid pro quo harassment and harassment by non-employees—are explicitly sexual harassment. As a form of sex-based harassment, hostile work environment harassment may be sexual or sexist in nature (based in stereotypes or assumptions about one's sex).[8-11] Legal scholars critique the limited scope of sexual harassment and relative neglect of sexist but non-sexual harassment,[12,13] concluding that existing laws and precedent fail to adequately understand or address both sexual and non-sexual sex-based harassment.

Victims may experience multiple types of sex-based harassment at once, or harassment that is also tied to discrimination based on other factors besides sex. When sex-based harassment charges are filed with the EEOC, they may be concurrently filed with allegations of other discrimination, such as by race or national origin. In a report discussing such charges, the EEOC found that 71 percent of such concurrent sex-harassment and race discrimination charges were filed by Black workers.[14] Despite the frequency of such co-occurring claims, victims experiencing multiple types of harassment and discrimination face barriers to legal recourse.

Appendix 2: More Information on Sex-based Harassment provides further information about the types of sex-based harassment and describes relevant laws and policies.

How prevalent is sex-based harassment?

The true prevalence of sex-based harassment is much higher than the number of charges filed, and opportunity youth likely face higher rates of victimization than the general population.

Estimates of experiences of sex-based harassment in the workplace for opportunity youth specifically have been hard to calculate because of underreporting and because few estimates focus on opportunity youth. One oft-cited statistic, drawing on governmental reports from the 1980s, suggests that 50 to 80 percent of working women have experienced sex-based harassment at one point, with only a fraction telling anyone and less than one in 20 making a formal complaint.[15] In comparison, according to data from 2000, an estimated 13 to 31 percent of working men have experienced sex-based harassment[16]; and, as of 2009, men have made up about 20 percent of all sex-based charges and 16 percent of all sexual harassment charges filed with the EEOC.[17] More recent U.S.-based data on the prevalence of sex-based harassment is scant, but suggests similar rates of victimization.[18] Workers who are Black and/or Hispanic, Native or Indigenous, queer, documented immigrants, or undocumented immigrants are more likely to report sex-based harassment in the workplace.[19-21]

The number of sex-based harassment charges filed in fiscal year (FY) 2024 (15,438) is slightly higher than in FY 2023 (14,195), and both years are substantially higher than FY 2022 (11,090).[22] However, estimates are complicated by low levels of formal reporting and extremely wide variation in survey-based findings, depending on how studies are conducted.[23] Further, the transition back to in-person work following COVID-related shifts to remote work may explain at least part of this increase—although opportunity youth and other young workers had a greater likelihood of working in-person jobs, even during the COVID-19 pandemic.[24] It is unclear whether these trends are reflected in sex-based harassment charges filed with state and local agencies, however, as state- and local-level data are not included in EEOC data and reporting data and practices differ widely across states.[25,26] The underreporting of sex-based harassment—both in formal complaint procedures, but also in surveys and other research—is problematic for multiple reasons. A lack of consistent data on the topic means that it is difficult to identify effective policy approaches that prevent its occurrence. Moreover, it means that sex-based harassment is a more widespread issue than any one data point would indicate.

What should youth-supporting professionals know about sex-based harassment in the workplace?

Opportunity youth tend to work in sectors and environments that put them at a greater risk of sex-based harassment/victimization.

Because young workers are more likely to find work in contexts in which they may experience more victimization, it is reasonable to conclude that opportunity youth might face greater risk of sex-based harassment than older adults. Specifically, researchers understand three things that suggest that opportunity youth are more likely than the average young worker to be at increased risk for sex-based harassment in the workplace: 1) the demographic groups to which opportunity youth are more likely to belong, 2) the workplace risk factors and experiences for which sex-based harassment is more common, and 3) the experiences many opportunity youth bring into the workplace.

Examples of jobs that involve greater risk of sex-based harassment include janitorial and property services, agricultural work, restaurants and food service, retail, home-based care, and hospitality.[27,28] Young people are more likely to work in roles—for example, as a tipped worker, in an isolated work context (for example, domestic care, janitorial, or hotel work), or in jobs with significant hierarchies in the workplace—that the EEOC most closely associates with sex-based harassment.[29] Evidence of workplace harassment in these workplaces is shared below.

- **Retail sales.** People working in retail sales occupations experienced about 13 percent of reported sexual harassment[30]—and a similar proportion of workplace violence overall[31]—while accounting for about nine percent of employed persons.
- **Restaurants.** Sex-based harassment affects both men and women who work in restaurants, but women face particularly high rates of harassment. One survey found that more than half of women working in restaurants experienced sexual harassment by managers, that nearly two thirds were harassed by coworkers, and that one third were harassed by customers—each week.[32] In the United States, the outsized role of tips in restaurant workers' incomes means that one's paycheck often depends on tolerating customer harassment.[33]
- **Hotels.** One study of hotel workers found that 58 percent experienced being sexually harassed by a guest.[34] Of these, almost half of all hotel workers had a guest answer the door naked or expose themselves. In this study, 56 percent of women who had been harassed by a guest said they did not feel safe returning to work after the incident, but many reported they felt there was nothing they or anyone could do about it.
- **Construction.** Nearly one quarter (23.6%) of women in construction reported experiences of sex-based harassment in the workplace, and nearly four in 10 reported considering leaving their job because of harassment or lack of respect.[35]
- **Health care and other care work.** Sex-based harassment in medical settings is common.[36,37] In home- based care settings, reporting has tended to be very low even though home care workers have rated sex-based harassment as a top concern.[38]

Opportunity youth may be more vulnerable to sex-based harassment.

As discussed in the introduction, sex-based harassment is usually driven by those who have more power over those who have less. Opportunity youth, who may not have prior work experience or adult role models, have fewer opportunities to build professional "soft skills" that allow them to succeed.[39] This, in turn, may make them more vulnerable to sex-based harassment that is driven by power imbalances when people in positions of power take advantage of employees' limited experience with how workplaces function or what is considered acceptable behavior on the job.

Opportunity youth may have themselves been fired when reporting harassment or know people who have—a consequence that may be more likely to happen in retail or customer service-related jobs where legal protections may be more sparse.[a] Opportunity youth are also more likely than their connected peers to report having a disability.[40] Disabled workers have high rates of experience with harassment.[41,42]

Economic vulnerability, such as living paycheck-to- paycheck or engaging in informal work, can increase vulnerability to on-the-job threats such as sexual harassment.

Opportunity youth may be at particular risk relative to others in their workplace. Those who feel like they do not have many other employment options may feel particularly reluctant to report or to rock the boat. Opportunity youth may specifically face publicly mandated requirements to gain and maintain employment and/or enrollment in an employment program to access public benefits, thereby creating reluctance to address sex-based harassment in favor of maintaining employment. Vulnerability to sex-based harassment is also high for youth who are engaged in sustenance sex work or sex work-adjacent professions (for instance, working in nightclubs or sexually themed restaurants), both because of unclear boundaries between harassment and expected behavior and because of fears that reporting harassment may jeopardize their employment and self-sufficiency.[43]

Sex-based harassment is detrimental to opportunity youth's potential career growth, physical health and wellness, and mental health.

Experiencing sex-based harassment can take a toll on one's personal health and professional standing and may lead to significant career and life difficulties. Well-documented professional harms from sex- based harassment include missing work, decreased job satisfaction, and lower productivity.[44,45] One study, focused on early career women, found that those who experienced sex-based harassment were up to 6.5 times as likely to change jobs within two years of the harassment, compared to those who had not been the targets of harassment—a change that precipitated financial distress.[46] Opportunity youth may be especially concerned about the downstream impacts of losing a job. These might include debt, lack of savings, and the possibility of losing housing.[47]

Sex-based harassment also has troubling effects on a victim's health and wellness. Those who experience sex-based harassment suffer worsened mental and physical health, present more symptoms of post- traumatic stress disorder, and report lower life satisfaction.[48,49] Sex-based harassment can also have compounding harms. For instance, the negative impacts of sex-based harassment have been found to be outsized when victims are young or early in their careers.[50] Sex-based harassment may not be the only form of harm inflicted on victims; for example, it is common to face both sex-based and racial harassment. The literature base is still developing regarding the health impacts of experiencing multiple forms of harassment and discrimination. One study of young Asian American women found that, in the past year, two thirds had experienced sexual harassment, more than three quarters had experienced racial harassment, and the two types were significantly correlated.[51] In this study, harassment due to one's sex was found to be consistently associated with worsened depression symptoms.

Past histories of trauma and mistreatment may lead opportunity youth to normalize the experience of harassment, react in ways that are harmful to their personal safety or best interests, or experience significant mental health consequences as a result of harassment. For example, a low sense of self-esteem and self-worth resulting from trauma may cause youth to disregard their safety and fail to properly address harassment.[52,53] Professionals also spoke specifically about the traumatic experiences of young people who have experienced or are currently experiencing commercial sexual exploitation and/or sexual abuse.[54] These youth have a heightened attunement to the possibility of harassment. Professionals find young people in these circumstances may either quit their jobs suddenly in response to crisis or try to withstand harassment out of a need for employment.[55] Finally, opportunity youth who have experienced trauma can be especially triggered or retraumatized by their experience of harassment or by structures within a workplace that are hierarchal and reinforce power dynamics, and may experience significant mental health consequences from sex-based harassment.

[a] A project advisor from the Research Alliance described the experience of young workers being fired after bringing up issues of harassment.

What can youth-supporting professionals do to prevent and address sex-based harassment?

Become familiar with the topic of sex-based harassment.

Start with the information included in this resource. Youth-supporting professionals can help by being conversational with the definitions and youth-friendly explanations of sex-based harassment in the *What is sex-based harassment?* section and in Appendix 1: Sex-based Harassment Types and Explanations, along with the relevant laws and state policies described in *More about laws and policies related to sex-based harassment* in Appendix 2. Additionally, youth-supporting professionals can review some of the following resources that discuss sex-based harassment from an advocacy perspective:

- Sexual violence and the workplace: A guide for advocates (National Sexual Violence Resource Center)
- An advocacy guide to addressing the impact of domestic and sexual violence, stalking and dating violence on the workplace (Workplaces Respond to Domestic & Sexual Violence)

Recognize risky elements of employers and workplace cultures.

While sex-based harassment may happen anywhere, and to anyone, some contexts are associated with greater or lesser risk of sex-based harassment. In fact, some experts have stated that "law is ineffective at reducing harassment" on its own,[56] indicating that—at the time of writing—it is worth giving extra consideration to the ways in which the workplace context can affect sex-based harassment.

Appendix 3: Considerations for Elements that Influence Workplace Harassment describes some aspects of workplaces and employers, their relevance to sex-based harassment, and questions that youth-supporting professionals should ask of current and potential employer partners. This information can be included in trainings or other activities with youth that introduce them to the topic of sex-based harassment. It is important to remind youth that, if they do face harassment, youth-supporting professionals are always there for them. Additionally, this information can be shared with employer partners to help them better recognize the risks of their own workplaces.

Monitor youth experiences.

Youth-supporting professionals should not stop being aware of their youth's well-being after they move into the workforce. For young people with whom they still have regular contact through program activities (e.g., in a cooperative work experience), youth-supporting professionals could implement a regular assessment of their safety and well-being. Some youth-serving organizations regularly implement broad, in-depth assessments such as the Casey Life Skills toolkit. Youth-supporting professionals may also consider adding direct questions about young people's safety and comfort in the workplace during check- ins, such as "Have you experienced any unwanted sexual behaviors, including comments or jokes, threats, touching, or other types of assault in the workplace or by someone who works with you?"[57]

Be sources of stability and support.

Experiencing sex-based harassment can be extremely isolating. Youth-supporting professionals play important roles as trusted adults who are invested in the well-being and long-term success of a young person, and do not encourage them to "stick it out" at a job in the face of harassment. Youth-supporting professionals should make it clear to the youth they work with that it is always okay to ask or tell them about sex-based harassment, even

if the youth has concluded their formal involvement in a program. Youth-supporting professionals can help youth who have experienced sex-based harassment decide what course of action they would like to take, if any. Additionally, they can serve as third-party advocates to youth and help them document instances of harassment and how it is handled by their employer.

Youth-supporting professionals should also account for the way their own organizations' principles or approaches for working with youth can help young people recognize, avoid, and/or process sex- based harassment. How an agency works with young people—for example, through healing-centered approaches, incorporating positive youth development, or promoting health—are aligned with how they can also handle instances of sex-based harassment. For example, healing-centered approaches (also known as trauma-informed approaches) work within principles of safety; trustworthiness and transparency; peer support; collaboration and mutuality; and voice and choice.[58] Each of these factors is aligned with how youth- supporting professionals should approach conversations about sex-based harassment with young people: sensitively and safely prioritizing their autonomy and decision-making capabilities. Although there seems to be a clear alignment between healing-centered approaches and the topic of workplace sex-based harassment for youth, little research or practice-oriented materials connect them. Future work should examine and teach how healing-centered approaches can support young people, including opportunity youth, as they navigate the workplace.

Help employers understand the consequences of sex-based harassment.

Sex-based harassment is costly to employers. For each of the past three fiscal years, monetary payouts for sex-based harassment claims in the United States have exceeded $140 million.[59] Beyond legal payouts, employers have to contend with turnover, absenteeism, and other interruptions to work that result from sex-based harassment—regardless of whether or not the harassment is ever formally reported to the employer or EEOC.[60] Employers can also incur damages to their reputations via word of mouth and the press.[61] Youth-supporting professionals can vet the employers they work with by requesting their policies related to harassment and discrimination and by learning about their track record with youth workers. When examining policies, youth-supporting professionals should also consider whether they are likely to be understood by a young person and whether they are available in multiple languages.

Appendices

Appendix 1. Sex-based Harassment Types and Explanations[62-64]

Type of sex-based harassment	Formal definition	Youth-friendly explanation
Quid pro quo	A person in power demands a sexual favor in return for an employment action or benefit. Employment benefits could include keeping a job, obtaining a promotion, or receiving other favorable treatment.	Coworkers or managers ask or tell you to do something sexual, or insist that you tolerate sexual behaviors or remarks, in exchange for anything related to your job.This behavior should never occur. Even if it is implied rather than said directly, this behavior is still unacceptable.
Hostile work environment	Sexual- and sex-related harassment that has the purpose or effect of unreasonably interfering with an employee's work performance or of creating an intimidating, hostile, or offensive working environment. Actions that may lead to a hostile work environment can include unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual or non-sexual nature but based on one's sex.	If coworkers or managers are behaving in ways that noticeably disrupt your ability to do your job—and if that behavior is sexual or related to your sex or sexual orientation—it may be creating a hostile work environment.
Harassment by non-employees	Sexual- and sex-related harassment that is perpetrated by someone other than an employee (such as a client, customer, or vendor). Harassment by non-employees is the employer's responsibility if they are or should have been aware of its occurrence.	Sex-based harassment at work is never acceptable, even if it is done by people who you don't work with (including if you know them from outside of work). Your employer has a duty to prevent harassment by non-employees, and to meaningfully address it if it does happen.

Appendix 2. More Information on Sex-based Harassment

More about the types of sex-based harassment

Quid pro quo harassment is a concept exclusive to sex-based harassment.[65] For victims of quid pro quo harassment, sex-based harassment may involve economic abuse or exploitation, as wages or benefits may become contingent upon tolerating harassing behavior. Notably, quid pro quo harassment also affects other employees besides the specific target of the harassment.[66] This is due to sexual favoritism: When a person in power grants an employment opportunity or benefit based on an employee's submission to implicit or explicit sexual harassment, other qualified employees are then denied that opportunity or benefit as a result of the harassment. In addition to the actual victim of the quid pro quo harassment, these third-party employees may also have grounds to claim sex-based discrimination.[67]

Courts have established a high threshold for proving **hostile work environment** sex-based harassment claims.[68,69] A breadth of legal scholarship chronicles the history and evolution of quid pro quo and hostile work environment harassment jurisprudence since Title VII (for more information on Title VII, see *More about laws and policies related to sex-based harassment* below). Broadly, hostile work environment harassment cases are often viewed as less straightforward, more ambiguous, and overall harder to prosecute than quid pro quo harassment claims.[70,71]

Approximately 24 percent of workplace-based violence (including sexual harassment) is perpetrated by someone with a **personal, not professional, relationship to the victim**.[72] Workplace violence includes verbal, physical, and sexual abuse. A study conducted in 2006 found that, although verbal abuse was the most prevalent form of workplace violence (31%), physical (15%) and sexual abuse (4%) followed respectively.[73]

More about laws and policies related to sex-based harassment

Title VII. Title VII of the Civil Rights Act of 1964 (Title VII) is the landmark federal law prohibiting discrimination in employment based on race, color, sex, religion, or national origin. Title VII is the most commonly discussed legislation in the context of sex-based harassment.[74-79]

Equal Employment Opportunity Commission. The Equal Employment Opportunity Commission (EEOC) is the main federal entity responsible for enforcing Title VII and other federal laws pertaining to sex- based harassment in the workplace. The EEOC produces official publications related to sex-based harassment.[80-82] Other organizations and experts examine EEOC guidance or recommendations for addressing sex-based harassment or discrimination in the context of specific experiences or sub-topics: domestic or dating violence,[83-85] sexual violence,[86-88] stalking,[89-91] sexual favoritism,[92] mandatory arbitration,[93] recidivist harassment,[94] and employer liability.[95]

Title IX. Title IX of the Higher Education Amendments Act of 1972 (Title IX) is the federal law enforced by the U.S. Department of Education and prohibiting sex-based harassment and discrimination in federally funded public education and educational employment settings. Research suggests that courts are divided over whether Title VII, Title IX, or both may apply to workplace harassment or employment discrimination in educational institutions.[96,97]

State and local policies vary. Far fewer sources focus on state- and local-level laws, policies, and regulatory entities addressing workplace sex-based harassment. One web source delves into workplace training requirements by state, including anti-sexual harassment trainingb as well as workplace civility and bystander intervention training.[98] Another source directs to local EEOC district or field offices in each state and summarizes notable state-specific policies for filing a workplace harassment claim.[99] Most resources simply mention that some states also have laws and protections against workplace harassment and discrimination, which may apply.

[b] Importantly, there is little evidence that employer-mandated sex-based harassment trainings are effective in preventing harassment. Researchers have suggested that employers do more thorough *education* on harassment, rather than boilerplate trainings that serve to protect employers' interests rather than those of employees (see, for example, Freyd & Smidt, 2019).

Appendix 3. Considerations for Elements That Influence Workplace Harassment[100-103]

Workplace element	Relevance to harassment	Questions to consider
Sexual harassment policies	In some workplaces, human resources departments and harassment policies are focused on preventing employer liability rather than preventing or effectively addressing harassment itself. Additionally, policies may be available only in English or written in ways that are not accessible for young workers.	• Can the employer share a copy of its sex-based harassment policy? • How are policies and trainings made accessible to all youth? • Is there a prevention and response plan in place for sex-based harassment?
Culture	Sex-based harassment may be normalized in workplace cultures that communicate in sexist or crude ways (including via sexist humor), or bring/encourage alcohol in certain workplace settings including after work hours.	• What is the workplace culture like? • What kind of guidance do employees get for appropriate behavior?
Organizational structure and hierarchies	Workplaces with strong hierarchies, or where high levels of value are placed on specific employees ("power players" or "rainmakers"), may have more harassment due to perpetrators' feelings of invulnerability and bystanders' belief that they need to tolerate or ignore bad behavior. Workplaces with unionized workers may have less harassment due to solidarity and greater perceived or actual power among victims.	• How is the workplace structured? • What protections or supports are in place for junior workers?
Workforce makeup	Workplaces with particularly imbalanced employee characteristics (e.g., almost all women or men, or no openly queer employees) may be more tolerant of some forms of harassment. Workplaces with many young workers may have more harassment due to generally lower levels of understanding of what sex-based harassment is and what rights workers have to a harassment-free workplace.	• Are efforts in place to support young people in the workplace?
Wages and benefits	Workplaces with low-wage workers or that provide needed benefits (health care, retirement) may expect workers to tolerate harassment due to a lack of other immediate options. Tipped work can bring the expectation that harassment from customers is or should be accepted.	• Are workers' benefits clearly explained to them? • Do supervisors provide clear explanations for what behavior is allowed from customers and coworkers?

Methods Note

The overall approach to developing this resource is described in the *Methods* section; this Methods Note provides more details on how sources for the resource were identified and reviewed for inclusion.

Initial search of peer-reviewed literature. We searched the peer-reviewed literature using relevant terms and phrases across four domains: workforce, sex-based/sexual harassment, opportunity youth, and other populations of interest. Examples of peer-reviewed literature databases used for this search included Academic Search Complete, OmniFile Full Text, PubMed, and Google Scholar. Example search terms included:

> *Employment OR "Job training" OR WIOA OR Workplace OR Reengagement OR "Workforce Development" OR Occupation* AND "Sex based" OR Sexual* OR Consent OR Rape OR Assault OR Battery OR Coercion OR Abuse OR Harassment OR Discrimination OR violence OR Rights OR Exploit* AND OSY OR unemployed OR "drop out" OR "disconnected " OR "opportunity" OR NEET OR "Not in Education, Employment, or Training" OR "out-of-school" AND parent* OR Pregnan* OR Expectant OR Vulnerable OR Victim* OR Survivor*

Grey literature search. We searched for research and resources published by organizations that focus on opportunity youth, employment rights, workplace harassment, and/or employment preparation. These included both nongovernmental and federal government (or federally funded) sources. For example:

Nongovernmental organizations included in the grey literature search were:

- American Association of University Women
- American Public Health Association
- American Youth Policy Forum
- Aspen Institute
- Center for Law and Social Policy (CLASP)
- Dibble Institute
- Futures Without Violence
- Hire Opportunity Coalition
- Institute for Women's Policy Research
- Jobs for the Future
- National Sexual Violence Resource Center
- Project WHEN
- YouthBuild

Governmental and federally funded pages and initiatives scanned were:

- Apprenticeship.gov
- CDC: Teen Pregnancy
- Family and Youth Services Bureau
- EEOC Youth@Work
- Reproductive Health National Training Center
- Workplaces Respond to Domestic and Sexual Violence
- Youth.gov

Results from initial searches. Initial peer-reviewed and grey literature searches resulted in 192 potentially relevant sources. Of these, 124 were found to be relevant to the resource and screened in full. We developed a coding schema to identify the

type of source (e.g., peer-reviewed article, fact sheet, brief/report, tool), *population of interest* (e.g., opportunity youth, all workers), relevance for broad *topics* (background on sex-based harassment, understanding experiences of sex- based harassment, addressing/preventing sex-based harassment), and relevance for notable emergent *themes* (e.g., equity, policies, employer influence, examples of harassment).

Targeted searches. Consultation with seven project advisors resulted in several additional topics for further searches: hospitality and sustenance sex work, relevant approaches to practice engaging opportunity youth, factors influencing reporting of sex-based harassment, and the effectiveness of legal approaches (laws and policies) for preventing sex-based harassment. We conducted supplementary targeted searches by pairing the below terms with "sex based harassment," "sexual harassment," or "sex harassment") and searching in the same peer-reviewed literature databases as the initial search:

- Hospitality and sustenance sex work (e.g., "sex work," "nightlife," "hospitality")
- Assessments (e.g., "life skills assessment")
- Relevant frameworks/approaches for practice (e.g., "strengths based," "relationship based," "trauma informed," "healing centered")
- Factors influencing reporting of sex-based harassment (e.g., "reporting mechanisms," "reporting policies," "reporting challenges" "United States")
- Effectiveness of laws and government policy for preventing sex-based harassment (e.g., "state law" AND "effectiveness," "sexual harassment prevention" AND "effectiveness" AND "law")

Targeted searches resulted in 61 potentially relevant sources, of which 26 were found to be relevant to the resource and screened in full. In total, 150 sources were reviewed and coded for this review. The results of the review were organized around three categories: *what is sex-based harassment*, *sex-based harassment and the law*, and *equity/considerations for opportunity youth*. The results of the search for each category are reported in the tables below.

Methods Table 1. Research and resource review: What is sex-based harassment?

Findings from review
How many sources were identified? The majority of sources (117 total) identified in our literature review provided insight into the basic question of "What is sex-based harassment?" • 98 sources defined sex-based harassment, provided examples of specific types, or described critical contextual influences on its occurrence (e.g., types of work associated with greater harassment). • 81 sources discussed fundamental background information about sex-based harassment, such as its prevalence or impact on well-being. • 62 sources discussed both.
What types of sources were they? • 31 came from peer-reviewed academic journals and 17 came from law journals. • Grey literature such as briefs, reports, tip sheets, and fact sheets made up 25 sources. • Webpages, blogs, FAQs, and resource collections comprised 19 sources and practice- oriented sources (e.g., handbook chapters, guides, training materials) comprised 14 sources. • There were a small number of miscellaneous sources such as lectures, dissertations, journalism, and opinion articles.

Findings from review
What were the focal populations of these sources? • 32 were focused on workers in general. • 31 sources had multiple focal populations (such as employers and practitioners or researchers and policymakers). • A relatively small number (12) were focused on specific demographics, such as female workers, queer workers, or young adults, and a similar number (11) focused on workers in specific industries (such as hospitality and tourism or health care). • 8 were focused on employers, business owners, or managers in general. • The remaining sources were spread across smaller categories.

Methods Table 2. Research and resource review: Sex-based harassment and the law

Findings from review
How many sources were identified? • 59 sources identified in our literature review discussed state, local, or national policies relevant to sex-based harassment.
What types of sources were they? • 15 were published in academic journals and an additional 14 were law journal articles. • Briefs, reports, and fact sheets made up 11 sources. • 6 of the sources were practice-oriented materials such as training materials, FAQs, and resource collections. • There were 6 blog entries and a handful of additional miscellaneous source types.
What were the focal populations of these sources? • The focal populations for these sources were diverse. • Approximately one third of sources (18) discussed workers in general. • 7 sources discussed specific demographics of workers (e.g., female workers, queer) and 5 more focused on workers in specific industries or job types. • 15 resources included practitioners in the workforce space (including youth-supporting professionals and workforce consultants) in their likely audience.

Methods Table 3. Research and resource review: Considerations for opportunity youth

Findings from review
What types of sources were they? • 19 were published in academic journals and an additional 10 were law journal articles. • Briefs, reports, and fact sheets made up 19 sources. • 10 sources were practice-oriented materials, including webinars, guides, tip sheets, and tools. • There were 9 blog entries and a handful of additional miscellaneous source types such as book chapters and lectures.

Findings from review
What were the focal populations of these sources? • Opportunity youth were the focal population of seven sources. However, all of these resources had tangential rather than direct relevance to sex-based harassment. • 13 sources were largely focused on the general population of workers and 8 focused on demographic subpopulations (e.g., queer workers, youth). • 8 sources were directed toward subject matter experts such as criminologists, public health researchers, and advocates. • The remaining sources had populations of interest outside of the above groupings, or covered multiple populations.

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About the Authors

Sam Beckwith is a Senior Research Analyst at Child Trends and a member of Activate's Research Translation Team.

Colleen Schlecht, MPP, is a Senior Researcher at Chapin Hall and a member of Activate's Research Translation Team.

Katelyn Rust is a Research Assistant at Child Trends and a member of the Activate project team.

Nia-Simone Woods is a Senior Research Assistant at Child Trends and a member of the Activate project team.

Hannah Lantos, PhD is a Senior Research Scientist at Child Trends.

Jan DeCoursey,AM, is a Research Scholar at Child Trends and director of the Activate project.

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Module 4: Pregnancy and Parenting

What's Inside? Resources address the unique experiences of young parents, with emphases on young fathers and parenthood in the contexts of child welfare or justice system involvement.

Contents

Research on:

- Adolescent and young adult pregnancy
- Challenges, strengths, and resilience among young parents
- Parenting while being parented
- Navigating co-parenting
- Impacts of early parenthood on family systems and conflict

Specific practice approaches

- Intergenerational approaches
- Engaging caregivers in services
- Building on family strengths

Guidance for working with young fathers

- Young fatherhood in the child welfare and justice systems
- Engagement strategies

Practical tools

- Conversation starters
- Reflection and follow-up prompts
- Perspective-taking activities
- Concrete tips

Module 4 Navigation Matrix

Pregnancy and Parenting

This matrix provides an at-a-glance overview of the resources in Module 4. Use it to quickly identify each type of resource, overlap with other module topics, and the population(s) of young people emphasized. Click a resource title below to jump directly to that resource!

Resource Title	Topic Overlap:		Young People Experiencing...
Exploring the Dual Experiences of Parenting While Being Parented	♥		✓ Child Welfare System ✓ Justice System ✓ Homelessness ✓ Disconnection
Tips to Guide Young Parents and Adult Caregivers Through Young Parenthood	♥		
Understanding Young Fatherhood Within Child Welfare and Juvenile Justice Systems	♥		✓ Child Welfare System ✓ Justice System ✓ Disconnection
A Conversation Guide to Support Young Fathers in Child Welfare and Juvenile Justice	♥	✚	

Resource Types: Research Summary | Tip Sheet | Conversation Support

Topics: Healthy Relationships | Violence Prevention & Intervention | Pregnancy & Parenting | Sexual & Reproductive Health Care

ACTIVATE | A partnership between Child Trends & Chapin Hall

Exploring the Dual Experiences of Parenting While Being Parented

Asari Offiong, Brittany Mihalec-Adkins, Lee Ann Huang, and Amy Dworsky

Purpose

Young parents must often balance the experience of *being parents* with the experience of *being parented* by the adult caregivers in their lives (e.g., parents, grandparents, extended family members, foster caregivers, congregate care staff). To effectively support young parents, professionals must understand the relationships these young parents have with their own parents and other adult caregivers.

This summary describes research about the relationships between young parents and their adult caregivers, with additional considerations for professionals who support young people and families who face unique adversities. Youth and families who have been impacted by the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school and work may face additional challenges that can shape the experience of young parenthood, young parents' relationships with caregivers, and what they need from youth-supporting professionals.

Youth-supporting professionals can use the research summarized in this brief to support young parents (and their caregivers) as they navigate the dual experiences of parenting and being parented during the transition to adulthood.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Background

Although rates of adolescent pregnancy in the United States have declined significantly in recent decades,[1] nearly 141,000 adolescent girls ages 15 to 19 gave birth in 2023.[2] Young people who have experiences with child welfare and/or juvenile justice systems, homelessness, or disconnection from school and work (i.e., opportunity youth) are more likely than their peers in the general youth population to report a pregnancy and/or birth.[3,4,5,6]

- Based on recent data from the National Survey of Family Growth (NSFG), 41 percent of female opportunity youth reported ever experiencing a pregnancy and 32 percent reported having a child, which was twice as high as their connected peers.[7] Among male opportunity youth, 15 percent reported ever experiencing a pregnancy and 8 percent reported having a child.[8] Data show that teenage mothers are, on average, more likely than their peers to drop out of high school[9] or to experiencing higher instances of housing instability due to pregnancy.[10]

- A brief survey administered to unaccompanied youth and young adults experiencing homelessness across 22 U.S. counties found pregnancy and parenthood rates to range from 3–10 percent for youth ages 13 to 17, and 29–43 percent for young adults ages 18 to 25.[11]
- Research notes similar trends for youth who experience the child welfare system. In the National Youth in Transition Database (NYTD) survey, 38 percent of females had given birth by age 21.[12] Among young women in Pennsylvania who were previously in foster care, nearly 44 percent reported ever being pregnant.[13] Reports of maltreatment to child protective services are linked to higher rates of adolescent pregnancy.[14]
- About 25 percent of girls currently detained in the juvenile justice system report ever being pregnant.[15] Arrest history among high school students has been associated with becoming a parent before age 25.[16] In a study focused on youth who experience both the child welfare and juvenile justice systems, nearly 32 percent reported ever being pregnant or causing a pregnancy.[17]

Few studies capture the proportion of actively parenting youth who experience the child welfare and/or justice systems, homelessness, or disconnection from school and work. However, available research demonstrates the need to focus more on young parents with these experiences as they navigate parenthood and adolescence simultaneously.

Summary of Findings

In general, young parents have the same legal rights and responsibilities as adult parents under both federal and state laws—even when they are minors.[18] However, young parents under age 18 are also still legally entitled to caregiving by their own parents or caregivers. The legal and practical realities of *parenting while being parented* can create confusion about the respective responsibilities of young parents and their adult caregivers. Furthermore, parenting roles and responsibilities can vary greatly depending on the age and developmental needs and abilities of the young parent.[19,20,21] For example, the needs and parenting abilities of a 14-year-old parent are likely to be very different from those of a 22-year-old parent, given brain development and executive functioning skills.[22,23]

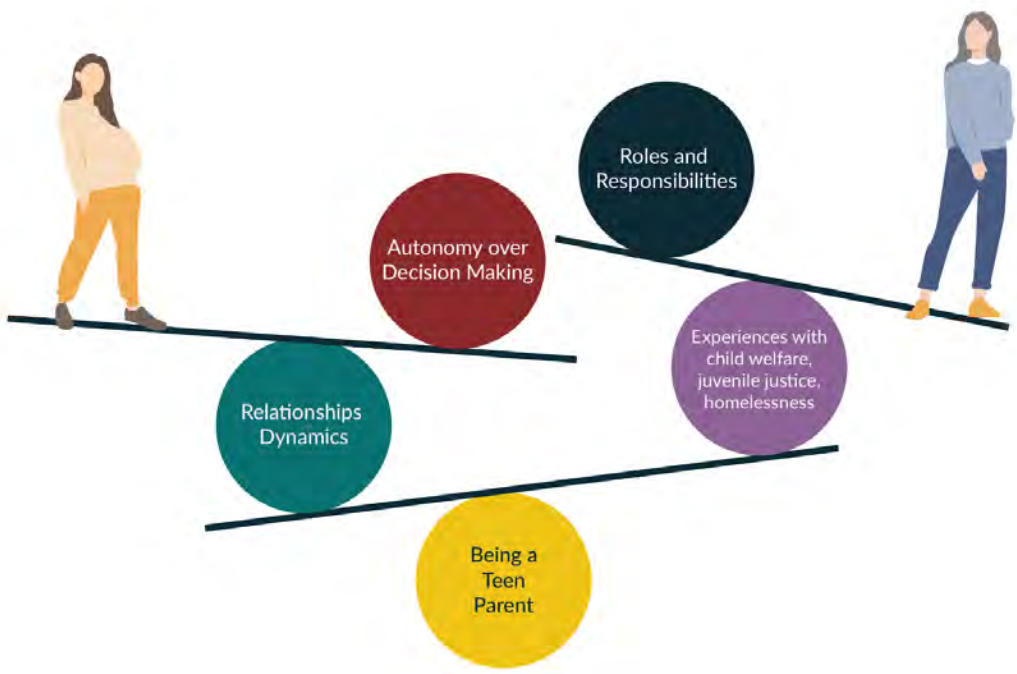
A balancing act: Normative adolescent development and early parenthood

Adolescence can be a challenging time for all youth, introducing changes and even strain into their relationships with parents and caregivers. Normative adolescent development involves taking risks, exploring identities, and seeking more independence from caregivers—behaviors that can shape identities among emerging adults.[24] Adolescence is also marked by increased conflict between youth and their parents/caregivers, as young people negotiate their increased desire for independence and push back against parental authority.[25,26,27] While often stressful, developmental science shows that parent-adolescent conflicts are also important opportunities for relationship change and evolution, as adolescents and parents adjust to the young person's shift away from childhood and toward emerging adulthood.[28]

Changes to familial relationships during adolescence can be further complicated when an adolescent becomes a parent themselves.[29,30] Like most adolescents, adolescent parents are learning to navigate what it means to be independent. For adolescent parents, independence also includes making decisions about their child and experiencing shifts in roles, responsibilities, and relationship dynamics in their families.[31,32]

A small body of research has found that adolescent parents face "conflicting parenting and developmental demands," which can be a source of increased and unique parenting stress.[33] In interviews with 31 young adults who became mothers as adolescents, respondents described growing up with their own children (e.g., "we grew up together") and handling the "balancing act."[34] The balancing act is defined as juggling the demands of parenthood while navigating the experiences of adolescence.[35] Based on the research identified in our scan, three central ideas emerged around what young parents and their adult caregivers find themselves having to balance: (1) *relationship dynamics*, (2) *autonomy and decision-making power*, and (3) *roles and responsibilities*. When available, we specifically highlight research about youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school, and what additional considerations are critical to understanding their experiences of parenthood.

The following graphic visually depicts the difficult balancing act young parents and their adult caregivers may experience in this unique developmental period—and in the unique context of adolescent parenthood.



Young parent-caregiver relationships: Shifting dynamics, conflicts, and complexities

Holistically supporting young parents (e.g., adolescent parents) involves attending to the relationships that they have with their own parents/caregivers—especially when these young parents are often *parenting while being parented*. For young parents who have experiences with the child welfare and/or juvenile justice systems, homelessness, and/or disconnection from school or work, relationships with caregivers may be subject to additional complexities or challenges; however, research in this area remains underdeveloped.[36,37] In some cases, conflict can lead to a young person being kicked out of the home, which

may affect their likelihood of becoming homeless, engaging in risky behaviors, or dropping out of school.[38] Although the research about young parents is limited, youth-supporting professionals can help young parents and their adult caregivers navigate these challenges and foster an environment in which both the young parent and their child(ren) can thrive.[39]

Adolescents' transition into parenthood marks a significant turning point in the adolescent-caregiver relationship.[40] One unique study explored the experiences of mothers of adolescent parents during their transition to early grandparenthood, finding the transition to be abrupt and challenging for some families.[41] Caregivers' reactions to and feelings about their adolescents becoming a parent can include anger, fear, disappointment, or excitement.[42,43] Meanwhile, young parents in some studies have reported not feeling emotionally supported by their parents or other caregivers during their transition to parenthood.[44] Juggling the interpersonal and logistical demands associated with young parenthood can be very challenging, as illustrated in this quote from a young mother (one of 31 participants interviewed in a randomized control trial of the Minding the Baby® home-visiting program):

> *"I had three kids, and I didn't have a job. I was still stayin' home with my mom. It was just stressful. I didn't have no income… We were all sharin' one bedroom, so that was very stressful. Then just dealin' with tryin' to understand how everybody feels, the kids, me, my mom at that time, how everybody was feelin'. It was stressful."* [45]

In some cases, the arrival of a new baby can lead to closer relationships between adolescents and their caregivers—even if their relationship had previously been strained or the caregiver was not happy about the adolescent becoming a parent.[46,47] For instance, in one study of young people experiencing homelessness, youth reported that, despite complex dynamics, they relied on help from family members or service providers when pregnant or parenting; these relationships served as supportive assets while parenting.[48] Other research has found that young mothers (ages 13-19) most commonly reported *their* mothers as a source of support immediately postpartum.[49]

Adult caregivers can provide critical support that benefits both the young parent and the young parent's child(ren).[50] For instance, the quality of the young mother–grandmother relationship is positively associated with the quality of the young mother's parenting.[51] Research also suggests that social support is important for the development of young parents' identities as parents.[52] Another study found that perceived social support during pregnancy was positively associated with adolescent parents' self-reported parenting efficacy and parenting satisfaction postpartum.[53] One study found that rural adolescent mothers recognized the value of getting help from their families, but also described a paradox wherein relying on that support may suggest acknowledgement that they lacked parenting-related competence.[54] Maternal support or support from other family members may decrease over time while relationship strain may increase.[55] Other research has indicated that family-related stress can adversely affect a young mother's maternal self-esteem[56] and that lack of support can be related to experiencing postpartum depression.[57]

Autonomy and decision-making power

Negotiating independence (e.g., autonomy to make decisions) is normal for adolescents and their parents and/or other caregivers.[58] A key part of this negotiation for young *parents* and their adult caregivers is determining how *much* autonomy the young parent has to make decisions about—and be "in charge of"—their child(ren)'s care. For example, some young mothers who had children as teenagers perceive a tradeoff between their own autonomy and the help they received from family during the transition to parenthood.[59] One young mother said:

> *"But like, um his [child's father] mom would help with the bath and I didn't like that at all. Like, I liked that she helped but like she was "you're doing it this way, you're doing it this time, this is what you do." Like she wasn't like "okay well you do this, you help me." It was "let me do it," let—she wasn't teaching. She was "well let me have her, let me do it."*[60]

Research has found that grandparents who mentor their *adult* children through the transition to parenthood try to strike a balance between their desire for involvement with a desire to not overstep (e.g., "I only give advice when I'm asked").[61] However, the dynamics are likely to be different in the case of young parents who are still being parented themselves.

In many cases, young people who are involved in the child welfare or juvenile justice systems already lack autonomy[62,63] and face higher levels of surveillance by professionals, including caseworkers, foster parents, group care staff, and judges.[64,65,66] Court systems reinforce power dynamics by being heavily involved in the daily decisions around—and options that are granted to—youth in the child welfare or justice systems. Restrictions on young parents' autonomy may be further compounded by perceptions that they are immature or unfit to parent.[67,68] Data from various child welfare databases indicate that children of young parents are more likely to face child protective service (CPS) investigations around maltreatment/neglect.[69] Each of these negative perceptions limits young parents' ability to make decisions for themselves and their children, inhibits where they can and cannot go, and diminishes their access to choices.[70]

Young parents and their adult caregivers may have different parenting styles or approaches informed by developmental maturity, personal background, and life experiences. In a study comparing the parenting behaviors of young mothers (under age 25) and adult mothers (ages 25 and older), researchers found that young mothers were less likely to use positive parenting strategies and more likely to use discipline practices such as spanking or time out. In the study, differences in parenting styles were often attributed to the developmental stage of young parents, who may not fully understand child development and require additional parenting guidance from their caregiver.[71] Another study found that adolescent mothers required support to provide nurturing care and responsive caregiving for their young children.[72] Conflicts between adolescent mothers and their adult caregivers frequently centered around the adolescent mother's childrearing decisions and caregivers' concerns about the adolescent mothers' choices or priorities.[73] Fostering stronger, supportive relationships between young parents and adult caregivers can lead to more conversations and modeling of positive parenting that does not undermine young parents.[74]

Roles and responsibilities

Many young parents live with their own parents or adult caregivers, even when they are legally able to live independently.[75] Adult caregivers can provide housing, financial support, child care, or support with decisions about the young child's care.[76,77,78] Young parents need and benefit from these concrete supports. In one study, direct infant care support[a] provided by a parent figure was associated with young mothers' increased sensitivity to their infants during interactions – a key indicator of healthy attachment between mother and child.[79] Black adolescent mothers who received financial support from their parents around the time of their child's birth were five times more likely to be enrolled in school or graduate by their child's first birthday than those who did not receive parental financial support.[80] The findings demonstrate the importance of financial support for young parents, even after accounting for other factors such as living situation, emotional support, or demographic characteristics.

Living arrangements and child custody

The living arrangements of young parents and their children can be more complicated when youth are experiencing homelessness or involved with the child welfare or juvenile justice systems.

- **Homelessness.** Many young parents experiencing homelessness rely on relatives or other adults to care for their children during periods of housing instability, which complicates roles and responsibilities among family members. One study found that only 32 percent of young women and 8 percent of young men ages 18-25 experiencing homelessness had physical custody of one or more children.[81] However, few shelters serve parenting youth under age 18, and some "family shelters" (for all ages) exclude males ages 13 or older.[82,83,84] These age restrictions limit young parents' ability to provide basic needs such as housing for their child(ren).[85]
- **Child welfare system.** By definition, adolescent parents in foster care do not live with their parents. Their primary caregivers are temporary foster caregivers, kinship caregivers (e.g., extended family) or support staff in congregate care facilities or independent living placements. Even after exiting foster care (e.g., to reunification or adulthood), young people may have complicated feelings about their relationship with the families and caregivers from whom they were removed.[86] In addition, monitoring or surveillance can be an obstacle for young parents in foster care, who generally experience additional scrutiny by adults in their lives.[87,88,89] Both monitoring and surveillance can lead to young parents' loss of custody and require adult caregivers to take on caring for the young child.[90,91,92]
- **Juvenile justice system.** Young parents who are incarcerated do not live with their children and may have little in-person contact with them. Few juvenile justice facilities have child-friendly spaces, facilitate communication between parents and children, or accommodate child visitation.[93,94,95] Consequently, adolescent parents who experience the justice system must rely on relatives or other adults for physical custody of their young child(ren). While much research is not exclusive to young parents, the reliance on relatives or other adults leads to stress and tension as young parents and their adult caregivers negotiate roles and responsibilities, including child visitation.[96,97,98,99]

[a] Direct infant care support was measured using eight items: "feed the baby," "dress the baby," "put the baby to bed at night or for a nap," "take the baby for walks or visits," "play with or keep her/him occupied," "change the baby's diaper," "protect her/him from harmful things," and "get up at night with the baby".

Conclusion

More research is needed regarding relationships between young parents and their adult caregivers – particularly among young parents who experience the child welfare system, juvenile justice system, or homelessness.[100,101] To date, most of the existing research has focused on young mothers and *their* mothers (i.e., the maternal grandmothers of young mothers' children). As such, the current evidence base may not be generalizable to young fathers or to relationships between young mothers and non-parental caregivers.

Although society often stigmatizes young parenthood,[102,103,104] many young parents view their new role as a source of motivation and hope for the future, and an opportunity to create a positive upbringing for their children.[105,106] Building on the knowledge from positive youth development, additional research could support the development of programs that foster and strengthen positive relationships between young parents and their adult caregivers.[107,108] A clear understanding of the balancing act of adolescence and parenthood will help professionals provide guidance and necessary supports to strengthen the relationship dynamics between young parents and their caregivers.

Methods

We used a multi-step process to develop this summary of research on young parents. First, we solicited input on priority topics from a Research Alliance (RA) comprised of youth-supporting professionals, subject matter experts, and young people; this group identified supporting parenting youth as a topic of interest. We facilitated an in-depth discussion with one RA member, a practitioner in the child welfare system, to inform the specific focus of the research summary and to identify key search terms, researchers, and/or resources to use in the targeted literature review.

We conducted an iterative series of scientific literature searches (using Google Scholar and EBSCO advanced search functions) to identify peer-reviewed research and grey literature sources published in 2010 or later, available in English, and based in the United States. Search terms included various combinations of terms related to key concepts, including the following: multi-generational and intergenerational involvement or co-parenting, young parent(s)/parenthood, and Activate's focal populations (i.e., child welfare system, juvenile justice system, disconnection from work/school, homelessness). Following an initial systematized search that yielded minimal results that met our inclusion criteria, we conducted targeted supplemental searches. In the final set of publications that informed the development of this research summary, we allowed select exceptions to include studies that did not meet our original parameters, including seminal studies published prior to 2010 and international studies that captured cultural context relevant to immigrant populations represented in the United States. Studies not meeting our original criteria were carefully reviewed for inclusion on a case-by-case basis.

Our initial search strategy yielded 154 results. We reviewed the titles and abstracts of each and screened out 93 articles that did not match our inclusion criteria or were duplicates. We then conducted a full text review of the 51 remaining articles, excluding articles that were not relevant or not methodologically sound, retaining 33 articles. Our second (supplemental) search resulted in an additional 68 articles, with 9 of those ultimately coded for inclusion in the research synthesis. An additional 63 articles were identified outside of our formal searches, including by reviewing reference lists of included articles and consulting with external experts and RA members. This approach resulted in a total of 105 unique articles included in the research summarized for this brief.

Once we identified a final list of articles, team members independently coded articles for central ideas and met weekly to ensure consensus and discuss any disagreements. As a result, three themes emerged (i.e., relationship dynamics, autonomy and decision-making power, and roles and responsibilities) around what young parents and their adult caregivers must balance; we then used these themes to organize the research summary. We obtained feedback from select RA members on both outlines and full drafts of the research synthesis and made revisions accordingly.

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About the Authors

Asari Offiong, PhD, MPH, is a senior research scientist at Child Trends and a member of Activate's Need Assessment and Research Translation Teams.

Brittany Mihalec-Adkins, PhD, is a research scientist at Child Trends and a member of Activate's Research Translation Team.

Lee Ann Huang, MPP, is a senior researcher at Chapin Hall and a member of Activate's Research Translation Team.

Amy Dworsky, PhD, is a senior research fellow at Chapin Hall and a co-investigator of Activate.

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Tips to Guide Young Parents and Their Adult Caregivers Through Young Parenthood

Asari Offiong, Brittany Mihalec-Adkins, Lee Ann Huang, and Amy Dworsky

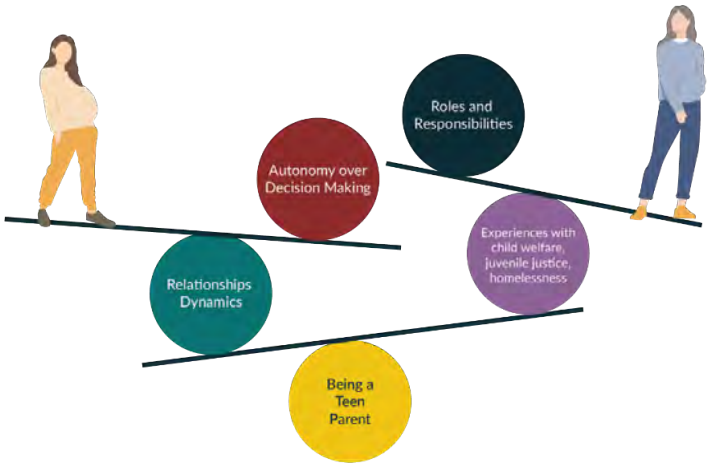
This tip sheet is for youth-supporting professionals who work with young parents who have experienced the child welfare or juvenile justice systems, homelessness, or disconnection from work and school. Its purpose is to provide guidance to these professionals about ways to help young parents and their adult caregivers navigate adolescent parenthood.

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Overview

As adolescents seek greater levels of independence, conflict and negotiation with their adult caregivers are developmentally appropriate.[1,2] When adolescents become young parents, their relationship dynamics with their adult caregivers change further.[3,4] As summarized in our research brief, young parents find themselves having to balance shifting relationship dynamics and assume new roles and responsibilities, while adult caregivers may find themselves having to give young parents more autonomy and decision-making power.[5,6,7] These changes require both young parents and their adult caregivers to interact and communicate differently. The relationship between young parents and their adult caregivers may be especially complex when the young person has experienced the child welfare or juvenile justice systems, homelessness, or disconnection from school and work.[8,9]

Supporting healthy family dynamics and relationships between young parents and their adult caregivers is essential. When young parents are supported, they can thrive and demonstrate the resilience needed to overcome the challenges and stigma often associated with young parenthood.[10] Investing in the relationship between young parents and their adult caregivers can have a positive effect not only on the young parent but also on the well-being of their young child.[11,12] Youth-supporting professionals can serve as the link between young parents and their adult caregivers and help strengthen their relationships.



The table on the next page highlights strategies youth-supporting professionals can implement when working with young parents and their adult caregivers, whether directly or indirectly.

Opportunities for professionals to support young parents and their adult caregivers

Educate young parents and caregivers on adolescent development	• Connect with adult caregivers to help them understand their role as the young parent transitions into adulthood. • Develop or share resources that explain the key features of adolescent development, particularly around adolescents' increased desire for independence. • Promote positive parenting strategies and disciplinary practices.
Promote young parents' self-efficacy[13]	• Use strengths-based language to help promote growth and increase young parents' confidence in parenting. • Encourage caregivers to make space for young parents' decision-making autonomy. • Set achievable goals and celebrate young parents' achievements.
Foster strong, healthy youth-adult relationship dynamics[14]	• Identify behaviors and patterns that may contribute to conflict between young parents and their caregivers. • Encourage family nights and activities to create opportunities for positive memories. • Provide opportunities for young parents and caregivers to safely, non-judgementally, and respectfully share their feelings about young parenthood.
Equip young parents and adult caregivers with strong communication skills	• Connect young parents and their adult caregivers to programs that focus on adolescent and child development and enhance family well-being. • Teach young parents how to ask for specific forms of help while setting or maintaining boundaries. • Facilitate conversations between young parents and their adult caregivers about the types of support that are helpful vs. unhelpful.
Assist with clarifying caregiving roles and responsibilities[15]	• Become familiar with local programs that provide additional support to young parents. • Co-develop a caregiving plan with young parents to clarify their responsibilities and decision-making autonomy and discuss their support needs, including child care, housing, and money, with their adult caregivers. • Help young parents who do not have physical custody of their child to be actively involved. Careful considerations should be taken when there are safety concerns for the child or the other co-parent.

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ACTIVATE | A partnership between Child Trends & Chapin Hall

Understanding Young Fatherhood Within Child Welfare and Juvenile Justice Systems

Asari Offiong, Karlee Naylon, Lee Ann Huang, Samuel Beckwith, and Mindy E. Scott

Overview

This research summary is intended for youth-supporting professionals who work closely with young parents who have experienced the child welfare and/or juvenile justice systems. The summary aims to support these professionals' understanding of factors that drive young fathers' behaviors, opportunities, and/or decisions.

Specifically, the summary describes research about the multiple factors that shape young men's introduction to and experiences of fatherhood, particularly among those fathers who have also experienced the child welfare and/or justice systems. Societal, systemic, interpersonal, and individual factors all influence young fathers' experiences. Below, we summarize research that describes the following:

- How societal views of young parenthood and masculinity frame the role of fathers during pregnancy and childrearing
- The ways in which young men's involvement in systems restricts their engagement with their children and influences coparenting dynamics
- How past experiences, family dynamics, and personal desires influence fatherhood

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

The research summary first provides background information about young fatherhood. Then, it turns to a discussion of research about the multiple factors that shape and influence young fathers involved in the child welfare and/or juvenile justice systems.

Background

Pregnancy and parenthood are common experiences among youth in the child welfare and/or justice systems.[1,2,3] Although much of the data on pregnancy focuses on young women, data from multiple settings indicate that fatherhood is also common among these youth and merits additional research. In the California Youth Transitions to Adulthood Study (CalYOUTH), roughly 17 percent of male participants with a history in foster care reported fathering a child and 37 percent reported getting someone pregnant by age 21.[4] In another study among youth in foster care from Missouri, male participants who transitioned from foster care before age 17 were more likely to report fathering a child from the ages of 17 to 19.[5] The findings were surprising but were linked to the perception that longer durations in foster care as a young adult provided males with access to more supports and resources. Similarly, data from the Survey of Youth in Residential Placement indicate that 15 percent of males in custody have fathered a child.[6] Other data sources suggest that the odds of becoming a parent by age 25 are roughly 70 percent higher for young men who have ever been arrested than those who were never arrested.[7] Due to poverty and limited access to

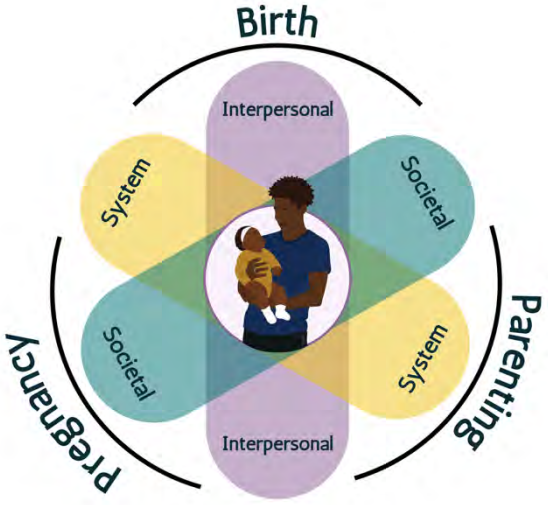
services in their communities,[8] young fathers often experience heightened disadvantages specific to employment, financial stability, and housing stability.[9]

When young parenthood is discussed in research, service, or program contexts, conversations tend to focus on young mothers rather than young fathers,[10,11,12] despite the extensive body of research that demonstrates the immense value of fathers' engagement on a child's behavioral, emotional, and educational outcomes.[13] There are fewer interventions and supports to meet young fathers' service needs, and less research is conducted to understand their experiences and service needs.[14,15] In instances in which fathers are discussed, attention is often focused on potential risks to their children, or fathers themselves are viewed as an afterthought.[16,17,18]

Researchers who study fatherhood illustrate how societal, systemic, interpersonal, and individual factors influence the father's well-being. This framing acknowledges that people—and fathers—are a reflection of larger communities and systems, which shape their attitudes, decisions, and behaviors.[19] Applying this framing is particularly useful when working with and supporting youth in child welfare and/or justice systems. The unique experiences of being involved with these systems and/or experiencing challenges like homelessness inform who young parents interact with, what rules and/or restrictions they must abide by, what kind (and degree) of access to resources they have, and how they view themselves.[20] Considering multiple factors also increases understanding of how young children's well-being and development are impacted by their fathers' own experiences.[21]

Below is a visual depiction that reflects the intersection of the four levels (societal, systemic, interpersonal, and individual) and their cumulative influence on young fathers who have experiences in the child welfare and/or juvenile justice systems. At each level, and depending on the age of their child, young fathers may experience unique barriers or facilitators that impact their ability to parent effectively.[22,23] In addition, nesting parenthood within the critical stages of adolescence and young adulthood—during which young men are changing developmentally, emotionally, and socially—requires a unique understanding of how the experiences of being an adolescent, transitioning to adulthood, and becoming a father all intersect.[24] Youth-supporting professionals should understand and recognize the challenges and opportunities that young fathers experience at all four levels and identify safeguards to help them thrive in their roles as fathers.

Figure 1: Multiple Influences on Young Fathers in Child Welfare and/Juvenile Justice Systems



Findings

The findings are organized by each of the four levels: societal, systemic, interpersonal, and individual. For each level, we present and synthesize key findings from the available literature, including research gaps and implications for practice.

Societal influences

Negative perceptions of young fathers

Society often views young fathers as uninvolved in their children's lives, an inaccurate stereotype for many.[25] Many youth experiencing the child welfare and/or juvenile justice systems face discrimination and bias,[26,27,28] stigma that can be compounded among young fathers involved in one or both systems. Even when they are present in their children's lives, their performance as fathers is often scrutinized.[29,30,31] One study found that young fathers reported higher levels of "felt stigma" (beliefs that others thought that they were a failure or needed too much help) related to young parenthood than young mothers.[32]

Even though service providers such as social workers may agree that fathers would benefit from a variety of supportive services,[33] researchers note a lack of integrated health care, education, or parent skill-building supports for young fathers.[34] More specifically, research notes that "beginning in the prenatal period, men often encounter healthcare and insurance policies and practices focused exclusively on mothers and birth outcomes, with minimal attention to the interests and needs of young fathers."[35] Fathers (not young fathers specifically) have reported difficulty navigating the health care system,[36] and identifying their role in prenatal care as secondary or supportive to the mother.[37] Rather than provide information directly to young fathers, for example, some services may rely on the mother to pass along information[38]; those seeking to engage young fathers in research have also relied on young mothers as the access point to young fathers,[39] further conveying the perception and narrative that fathers are uninvolved.

Social expectations of fathers

Some young fathers experience a tension between prevailing attitudes around fathering—some of which assert that men should be providers and take responsibility for their children,[40,41,42] while others perpetuate perceptions that "most dads aren't around" (as stated in one qualitative study).[43] Traditional societal norms around fatherhood (emphasizing fathers' roles in providing economic support) may motivate men to pursue higher-earning opportunities,[44] but such career changes are not always feasible for young fathers during adolescence and emerging adulthood. In fact, the difficulty of fulfilling the provider role may be a source of significant stress for young men.[45,46] At the same time, some young fathers may align more with modern ideals of fatherhood that emphasize warmth and interaction with their children, beyond simply providing economic support.[47] The intersection between societal views of fatherhood, young parenthood, and young people in the child welfare or justice systems serves as a foundation for how young fathers experience systems and interact with their providers, families, coparent(s), and child(ren).

Systemic influences

Young fathers who have been involved in the child welfare and/or juvenile justice systems may face challenges that restrict their ability to parent effectively, due to policies and/or the attitudes of youth-supporting professionals with whom they interact. Harty describes the experience of young fathers in foster care as "fathering within the context of a restrictive system," wherein the level and means of fathers' involvement with their children are bound by rules imposed by the foster care system, including placement curfews, limits on overnight stays, and approval for out-of-state travel.[48] Additional systemic barriers for some fathers include restricted visitation rights or abilities based on their own incarceration, the residential

location of their child and/or the child's mother, whether their child and/or child's mother are involved in the child welfare system, or assumptions by service providers about fathers' interest or ability to parent.[49,50,51,52]

Young fathers involved in the child welfare and/or juvenile justice systems may also interact with one or more additional systems, including human services, education and workforce development, and various health systems. When these systems are supportive and collaborative, they may provide the holistic resources that young fathers need to successfully navigate young parenthood and young adulthood.[53,54]

Experiences with the human services system as a young father

Human services is a broadly defined field, but it generally refers to the collective of public and community services that aim to help individuals meet their basic needs, improve their overall well-being, and achieve stability in various aspects of their lives.[55] Human services (e.g., education and career supports, life skills programming, parenting skills courses) are more likely to effectively support engagement among young fathers when they are multidimensional and contain interventions to accomplish the following:[56]

- Build self-sufficiency
- Strengthen physical and mental health
- Support housing and financial stability
- Strengthen coparenting and healthy relationship skills
- Share information about laws and policies related to topics that include (but are not limited to) paternity, child support, custody, and visitation

However, supportive services offered for expectant or parenting youth in the child welfare and/or juvenile justice systems—for example, home visiting, visitation, and supervised play—are often focused on (or exclusively oriented around) supporting the young mother.[57,58,59]

Reluctance to receive human services due to negative experiences

Beyond the scarcity of services focused on fathers' needs, young fathers with negative experiences in the child welfare and/or juvenile justice systems may be reluctant to engage in programming that does exist. For example, organizations administering Responsible Fatherhood programs[a] have reported challenges in identifying, engaging, and retaining young fathers. Young fathers entering the program with criminal histories have reported general distrust of programs, a reluctance to participate in services due to negative past experiences with other systems, a fear that information they share about their experiences might be "used against them," and doubt that programs could understand or meet their specific needs.[60]

Youth-supporting professionals working in human services should also consider their role in helping young fathers navigate societal factors, including general stigma and discrimination. In an evaluation of Responsible Fatherhood programs, fathers and program staff described ways in which stigma and societal norms informed their interactions with systems, and in turn hindered their ability to coparent.[61] For instance, several program staff described how many fathers experienced unaddressed mental health issues and family courts that favored mothers and other caretakers ahead of fathers (e.g., granting custody to a maternal grandparent instead of the father).

[a] Responsible Fatherhood is a federally funded program for fathers ages 18 and older with children ages 24 and younger, providing comprehensive healthy relationship and marriage education services, as well as job and career advancement activities to advance economic stability and overall family well-being. As part of the program's routine efforts, it supports fathers with histories in child welfare and juvenile justice involvement.

Experiences with education and employment systems as a young father

Youth who have been involved with the juvenile justice system commonly experience poorer academic performance, greater frequency of suspension or expulsion from school, and higher likelihood of high school dropout, relative to their peers.[62] Due to stigma around any criminal justice system involvement,[63] being arrested and convicted before age 26 has been linked with underemployment and lower earnings in young adulthood.[64] Youth involved in the child welfare system are less likely than their peers to experience high academic achievement, complete high school, or enroll in and complete postsecondary education.[65,66]

Low levels of education and high rates of unemployment make it challenging for young fathers to generate income to support their families and be involved in their children's lives.[67] In addition to requiring young fathers to navigate the conditions of probation or parole, a lack of employment has detrimental impacts on their health care coverage and access to stable housing post-incarceration.[68] Following incarceration, interruptions to education and employment may further put young fathers at a disadvantage in the workforce.[69] These challenges may be even more salient among youth currently or formerly involved in the child welfare and/or juvenile justice systems.

Intersection of employment and child support mandates

Intertwined with poor educational and employment outcomes is the issue of child support. Scant research has investigated how child support expectations and enforcement practices impact young parents involved in the child welfare or criminal justice systems. But research with fathers, more generally, describes fathers' challenges associated with child support, particularly among those who are unemployed or underemployed or incarcerated. For example, child support and visitation are separate in the legal system, which can be confusing to fathers—especially those without access to adequate legal representation.[70,71,72,73] Punitive child support enforcement policies (i.e., being arrested for unpaid child support) may limit young fathers' involvement with their children—particularly when they are involved in the child welfare system, where their ability to contribute financially tends to be prioritized over other forms of involvement.[74]

Ways to help young fathers navigate education and employment systems

In our review, we were unable to identify research focused on engaging young fathers who are exiting the child welfare and/or juvenile justice systems in the education and employment systems, which hinders our understanding of their unique experiences navigating these systems. However, research on fathers and fatherhood more broadly offers some insights; for instance, the National Responsible Fatherhood Clearinghouse identified key features of promising programs that may be applicable for providing workforce and education supports:[75]

- Providing participating fathers and families with incentives to boost engagement
- Incorporating methods and materials into curricula tailored for people with different life experiences
- Adequately training and staffing programs with individuals who believe in the program and its mission/goals
- Using curricula that are targeted and feature clear program objectives
- Using curricula that are based in theory and program elements shown to be effective in other contexts
- Using multiple teaching methods and personalizing information to support fathers on an individual basis
- Having staff who establish one-on-one relationships with fathers

Navigating the health system as a young father

Limited support and engagement of fathers in health care settings

While not focused on young fathers specifically, studies have shown that fathers report experiences of exclusion and lack of father-specific support in health care settings during pregnancy, birth, and the perinatal and parenting stages. A scoping review of 23 studies related to father supports in the perinatal period found that fathers lacked mental health supports after birth.[76] Such gaps in mental health service receipt can leave fathers feeling unsupported when trying to navigate paternal postnatal depression.[77] Fathers have been found to attend pediatric visits at significantly lower rates than mothers, and clinical guidance suggests using a variety of strategies to engage fathers and provide them with information and support related to parenting.[78] In some cases, fathers experienced both active and passive exclusion in family health care settings (e.g., being ignored, experiences of hostility when trying to engage).[79] Such experiences, in turn, can lead them to feel unhelpful, pushed away, and invisible.[80] In research involving young fathers in foster care, experiences from the prenatal stage through early infancy are mixed.[81] Some young fathers report being able to attend medical appointments (e.g., prenatal visits) regularly, whereas others were restricted from being present during their children's birth by their partners' parents and did not have caseworkers who would advocate for their rights as fathers.[82]

Interpersonal influences

A young father does not perform the acts constituting fatherhood in a vacuum, but rather in relationships with others, including their child's mother, their own parents/caregivers, and their extended family members and other adults—all of which can affect their engagement with their child.

Young fathers' relationships with coparents

The relationships between coparents have a significant influence on young fathers' engagement with their partners during pregnancy and with their children after birth.[83,84,85,86,87] Interventions specific to strengthening coparenting relationships can positively influence child development and father engagement.[88] In one study, incarcerated fathers ages 16 to 19 describe their hope for relationships with their child and partner that help them transform their lives so they can become less engaged in gangs or dangerous behavior and more focused on fathering.[89,90]

Even when both parents want the father to be involved in a child's life, relationship conflicts and instability pose threats to fathers' engagement.[91] Reasons for conflict may include fathers' engagement in risky or criminal activities, poor communication, the end of a romantic relationship, the involvement of multiple partners or coparents, varying or unmet expectations, difficulty managing responsibilities (i.e., financial support, parent-child visitation), or concerns about child safety.[92,93,94] However, the presence of a healthy and positive relationship dynamic with the mother can be transformative for a young father, both individually and in relation to their child.[95]

Youth fathers' relationships with adult caregivers

Young fathers' families and other adults in their lives can influence their fathering behaviors.[96,97,98] Youth aging out of foster care have reported feeling unsupported by their own families, expressing a desire for material support (e.g., child care), emotional support, and guidance.[99,100,101] In one study, incarcerated young fathers reported wanting to do things differently than their own fathers, with researchers concluding that "abusive, neglectful, and absent fathers were described as the cause of many of the participants' painful childhood experiences."[102] The Children and Family Research Partnership explained that many adolescent fathers grew up without positive relationships with their own fathers and, as a result, strongly desired to be a different kind of father.[103] They sought other family members, like uncles or grandparents; peers with children; or social media to learn how to be a more engaged, positive father. Discussions with young fathers revealed their heavy reliance on family members for guidance and support with becoming a new parent, which was mixed for young mothers who reported that involvement from their parents (i.e., grandparents) can be complicated at times.[104]

Individual influences

At the individual level, young fathers are shaped by their own attitudes and views of fatherhood, their personal life experiences with people and systems, and the fact that they are balancing emerging adulthood and young parenthood.[105,106,107] When layered with parenthood, normative adolescent development such as risk-taking, exploring one's identity, and seeking independence can be challenging for young fathers. Young fathers, like young mothers, may find themselves "growing up" with their young children and learning what it means to be a father by way of mistakes, relationships with others, and influences from society.

Experiences of trauma

Young men with experiences in the child welfare and/or juvenile justice systems often have histories of trauma exposures, either prior to or during their involvement in these systems.[108,109,110] In combination with their past life experiences, young men may find it stressful to navigate adolescence and transition into fatherhood. Many young fathers report engaging in substance use and having mental health challenges.[111] Like mothers, the birth of a new child can introduce the onset of postpartum depression and anxiety in fathers.[112] One study comparing adult and adolescent fathers found late adolescent fatherhood to be associated with less social support and higher frequency of depressive symptoms by the time the child was 3 years old, but dissipated when the child turned age 5.[113] Parenting stress was also associated with having been booked and/or charged with a crime by the time the child was 5 years old. These individual factors serve as the backdrop for how young fathers engage with their children, coparents, family members, and service providers. Without applying a trauma-informed lens to their work with young fathers who have systems involvement, youth-serving professionals risk viewing them as apathetic and disconnected.

Personal perceptions of fatherhood

As reflected in research about interpersonal influences, service providers and youth have expressed that a lack of healthy examples of fatherhood define young fathers' views of fatherhood and father identity.[114,115] In some studies, young fathers reported knowing what fatherhood *wasn't* but were not confident about what it *was* (i.e., what was required to be a good father), due to their own traumatic and abusive childhood experiences.[116] Additionally, incarceration or justice system involvement creates extended periods of

separation from children, which can introduce insecurities and fears around being a proactive father.[117] Despite these challenges, young fathers report enthusiasm and embrace the idea of being good fathers.[118]

Informed by societal views of fatherhood, young men in the foster care or juvenile justice systems tie their primary roles as fathers to being a provider[119] or to an idealized view of manhood.[120] The expectation of being a provider was closely tied to ideals about masculinity and the anticipation of needing to fill the role of protector for their children.[121] Qualitative research focused on adolescent fathers involved in the justice system has identified young men's preference for parenting sons over daughters because it represents an opportunity to "make their son a man" and encourage their sons to avoid activities that can lead to criminal justice system involvement.[122] These personal perspectives shape young men's identities as fathers and inform their decisions and behaviors when engaging with their children, navigating the relationships with the child's mother, and engaging with different systems.

Conclusion

Based on the available literature, youth-supporting professionals have multiple opportunities to support young fathers, both individually and in relation to their children—and across levels. Especially at the systemic and interpersonal levels, youth-supporting professionals can help alleviate challenges in accessing needed services, advocate for young fathers to be actively engaged in services, and foster healthy relationships between fathers and their children, coparents, and others. By understanding the multiple factors that inform young fatherhood, these professionals can apply a multi-pronged approach to working with young fathers, who must already navigate complex systems in child welfare and juvenile justice.

Methods

This summary of research and evidence-based resources on young fathers was developed using a multi-step process. First, we solicited input on priority topics from our larger Research Alliance comprised of youth-supporting professionals, subject matter experts, and young people—which identified young fatherhood as a topic of interest. We facilitated in-depth discussions with five RA members to inform the specific focus of the research summary and to identify key search terms, researchers, and/or resources to use in our targeted literature review. The Research Alliance members consisted of practitioners working in the child welfare and juvenile justice systems, university-based scholars, and a young father with experience in the child welfare system.

We conducted an iterative series of scientific literature searches to identify peer-reviewed research on relevant aspects of young fatherhood. To maximize the reach of the first stage of the review, our searches used various combinations of terms, including terms related to the Activate focal populations, fatherhood expectations, coparenting, parental rights, father involvement, and the development of a father identity. Using four academic databases (SCOPUS, PubMed, Web of Science, and Embase), our searches focused on literature published in 2010 and after, based in the United States or Canada. In addition, Research Alliance members shared relevant academic literature with us, especially seminal articles related to fatherhood, that may not have been encountered during our search of publications since 2010. While some of the seminal articles preceded 2010, we included them given their continued relevancy to the topic. Simultaneously, we identified and reviewed 33 gray (non-peer-reviewed) literature and resources related to the subject of young fatherhood. We identified gray literature by scanning the websites of relevant organizations such as Young United Parents, Casey Family Programs, Fathers and Families Coalition of America, and Children and Family Research Partnership. After removing duplicates and reviewing titles, abstracts, and full text, we revied and coded 55 articles and resources to inform this research summary. The coding schema captured each level (i.e., societal, systemic, interpersonal, individual) and primary topics of interest (e.g., attitudes around fatherhood, coparenting) for the research summary. Reviewers also wrote a brief (up to one paragraph) summary of primary takeaways from each reviewed article.

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About the Authors

Asari Offiong, PhD, MPH, is a senior research scientist at Child Trends and a member of Activate's Need Assessment and Research Translation Teams.

Karlee Naylon is a senior research analyst at Child Trends and a member of Activate's Research Translation Team.

Lee Ann Huang, MPP, is a researcher at Chapin Hall and a member of Activate's Research Translation Team

Samuel Beckwith, PhD, is a research scientist at Child Trends and a member of Activate's Research Translation Team.

Mindy E. Scott, PhD, is a senior scholar at Child Trends and serves as the principal investigator for Activate.

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A Conversation Guide to Support Young Fathers in Child Welfare and Juvenile Justice Systems

Asari Offiong, Karlee Naylon, Samuel Beckwith, Lee Ann Huang, and Mindy E. Scott

This conversation guide, informed by research and guidance from research and practice experts, provides youth-supporting professionals with important context and guidance for having conversations with young fathers who experience the child welfare and/or justice systems. The conversation guide has the following goals:

- Foster meaningful, supportive conversations with young fathers about their experiences and/or needs in navigating health, human service, and employment/education systems.
- Increase awareness about and identify the needs of young fathers with experiences in the child welfare and/or juvenile justice systems.
- Identify opportunities to support and connect young fathers to resources.

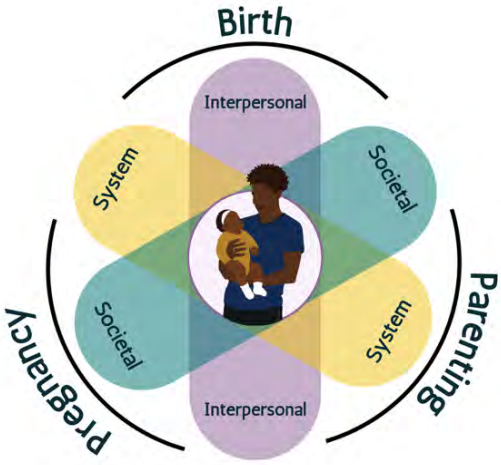
Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

This resource first reviews why it's important to prioritize young fathers' experiences and offers general considerations to help youth-supporting professionals engage with them. Pages 3-4 of this resource then orient youth-supporting professionals to the conversation guide. At the end, we provide additional resources for supporting young fathers.

The Importance of Prioritizing Young Fathers

Experiencing pregnancy and parenthood are common among young men who experience the child welfare and/or justice systems.[1,2,3] Data indicate that 15 percent of males who experience detention or residential placement have fathered a child.[4] A study of high school students found that the odds of becoming a parent before age 25 were 70 percent higher for young men who had ever been arrested in comparison to peers who had never been arrested.[5] Among a sample of youth transitioning to adulthood from foster care, about 17 percent of males reported fathering a child and 37 percent reported getting someone pregnant by age 21.[6] Although much of the available research and programs designed for young parents focus on mothers,[7,8] there is also extensive research on the benefits of father engagement on child development.[9] When fathers are engaged, their children may demonstrate more positive academic, social, and emotional outcomes[10,11] key factors to preventing risky behaviors in the short and long term.[12] In addition, research indicates that when young parents are supported, they are more involved and confident as parents and demonstrate overall personal development.[13,14,15]

Despite the noted benefits of supporting young fathers, limited resources exist that are specific to their experiences. Based on Activate's research summary focused on young fathers with experiences in the child welfare and/or juvenile justice systems, we know that young fathers receive less attention and support, in part due to societal attitudes around men and boys and perceptions of fatherhood.[16,17] There also are systemic, interpersonal, and individual influences that shape how young men navigate and experience fatherhood.[18] At each level, and depending on the age of their child, young fathers may experience unique barriers or facilitators that shape their ability to parent effectively.[19,20] It is important for youth-supporting professionals working in the child welfare and/or juvenile justice systems to understand and identify the specific needs of young men who are fathers.



How to Engage With Young Fathers

The following key considerations can help youth-supporting professionals prepare *before* engaging young fathers in discussions about their experiences and needs.

- **Become familiar with the young father:** Gather information about the young father from existing case files or by conducting intake assessment interviews to understand their past experiences, history, and intersecting identities. The linked document is an example guide of how to collect information on a young person. It will help to be aware of their relationship dynamics with their own family, co-parent, and other people in their life. Research on young fathers with systems involvement indicates high levels of exposure to trauma and increased mental health and substance use challenges, which impact fathers' behaviors and experiences.[21,22] Building a rapport with the young father will help the youth-supporting professional gain a clear understanding, rather than make assumptions, and to be open to fathers' perspectives.
- **Think about where the conversations are held:** Confidentiality and safety are critical issues for young people, but especially for those with experiences in the child welfare and/or juvenile justice systems. Young fathers report being distrustful of professionals and systems,[23] so it is necessary to create a safe space and communicate the purpose of having discussions about what supports they need along their parenting journey.
- **Realize that discussions about fatherhood might feel uncomfortable for young fathers:** Young men report often being dismissed or forgotten about in their roles as fathers,[24] and they may need time and space to feel comfortable discussing their needs. In such cases, to build rapport and trust, youth-supporting professionals should consider facilitating group sessions among young fathers. Studies of fatherhood programs reveal the benefits and value of support groups for young fathers, particularly when led by other fathers.[25,26] As a result, youth-supporting professionals may experience greater strides and ease in connecting with the young father individually after engaging them in group discussions.
- **Focus on fathers' assets in addition to their needs:** Young men with experiences in child welfare and/or juvenile justice systems are often viewed negatively by society.[27,28] Youth-supporting professionals can consider the application of a Positive Youth Development approach to their work with young fathers involved with the child welfare and/or justice systems.[29] For example, professionals can reiterate young fathers' value to their families, affirm their desires to be active and involved fathers, and recognize their strengths and resilience.

Using the Conversation Guide

Several practice resources focus on supporting young fathers' co-parenting and interpersonal relationships. This conversation guide is intended to help youth-supporting professionals working with young fathers in child welfare and/or juvenile justice systems *navigate the multiple systems with which young fathers interact*. Key systems include **health, human services**, **employment**, and **education**. For more information about young fathers' experiences with each of these systems, see the full brief on Understanding Young Fatherhood Within Child Welfare and Juvenile Justice Systems.

Break the ice

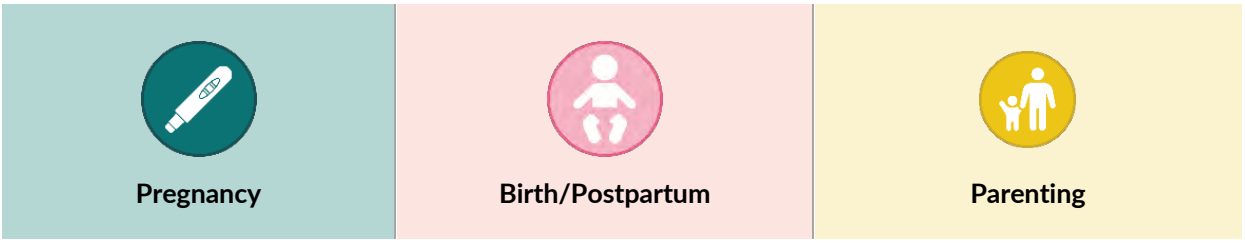
To start, youth-supporting professionals should break the ice by acknowledging common emotional experiences that young fathers may have. This is called normalizing—a counseling technique that helps the young person feel seen and validated that their feelings or behaviors are common, and not unusual. Additionally, general questions or comments can create a level of comfort, trust, and rapport. Consider the following prompts as warm-ups and a way to get familiar with the young father.

- *It's common for young fathers to feel unsure or sense pressure from the people around them. How are you feeling mentally or emotionally?*
- *Many young fathers are trying to figure themselves out individually, while also trying to learn and raise their children—which can be difficult at times. Tell me about your child(ren). How would you describe their personality?*
- *Being a parent has both ups and downs. What are the best parts of being a father for you? What have been the most difficult parts of becoming (or being) a father?*

Talk about systems

After breaking the ice and establishing a rapport, it is important to find out what systems young fathers need support with (i.e., health, human services, employment, or education). Pages 5-7 provide examples of system-specific discussion topics and prompts to initiate conversations, depending on where the young father is on their parenting journey.

The prompts address:



Based on available research, the topics provided represent critical discussions to have with young fathers and may lead to other topics not mentioned in the tool. It is important to broach these topics with care, sensitivity, and authenticity. The sample prompts intentionally focus on the young father—on his needs, perspectives, and experiences. When relevant and necessary, youth-supporting professionals can frame questions about co-parenting dynamics or other family members in a way that is needed to better understand the context. As youth-supporting professionals engage in conversations, they may not have direct or immediate responses for the young father on every topic. Nonetheless, these conversations create an opportunity to jointly identify and research available resources and/or referrals. In some cases, the conversation topics are intended to help the young father problem-solve and/or develop their own action plan.

Plan for next steps

Each conversation should end with next steps for either the young father and/or the young-supporting professional. Whenever possible, invite the young father to share their thoughts on the conversation and on any next steps they would like to prioritize. As a guiding principle, youth-supporting professionals should remember that the young father is the expert on their own life and should respect the father's feelings and decisions. Professionals helping young fathers navigate various systems should consider the following steps:

- Youth-supporting professionals should talk with their colleagues and other professionals about what they learn from young fathers. As noted in the available research about young fathers' personal experiences, there is still more to learn and understand about fatherhood experiences in adolescence. By discussing barriers and facilitators that young fathers generally experience in different systems, youth-supporting professionals can help address any challenges and better support young fathers. There may be opportunities, both organizationally and within the community, to compile resources and services that address young fathers' needs.
- Youth-supporting professionals should also maintain ongoing conversations with fathers. Young fathers, especially those with experiences in the child welfare and/or juvenile justice systems, encounter several challenges related to parenthood and in navigating the transition from adolescence to adulthood.[30,31] Ongoing conversations and check-ins with young fathers are critical to build rapport and ensure that young fathers receive the necessary support to navigate multiple systems.

This conversation guide is intentionally broad to maximize flexibility and help youth-supporting professionals tailor conversations to young fathers' varied experiences and identities. For example, young fathers with multiple children may need to discuss a variety of topics. In addition, the guide includes prompts that use positive framing and focus mainly on the young father's needs and experiences. We encourage youth-supporting professionals to adopt this framing in their interactions with young fathers.

Health Care Systems

Example pregnancy, birth, postpartum and parenting topics

Prenatal care	Substance use	Stress and well-being
Postpartum depression	Child wellness visits	Mental health/Therapy

Example Prompts

- Have you accompanied the mother to any pregnancy-related medical visits? What was that like for you?
- What questions do you have about the baby's development during the pregnancy?
- How are you feeling mentally or emotionally since learning about the pregnancy?
- How are you coping with everything? How do you cope with stress?

- [Baby not born] What, if any, conversations have you had with the mother about the birthing plan? What support would you like to help you feel prepared?
- [Baby is born] How did everything go with the birth?
- Have you and the mother identified a regular doctor/pediatrician for the baby?
- How have you been doing mentally since the birth of the baby? What about the mother?

- Is your child enrolled in a health insurance plan? How about you?
- Where does your child go for check-ups? How is that working?
- Have you been to the doctor for check-ups or emergency care this year?
- How are you handling the stress of being a parent?

Human Services

Example pregnancy, birth, postpartum and parenting topics

Eligability of services	Paternity	Receipt of public assistance
Legal rights	Parenting support	Social support
Custody and visitation		Childcare

Example Prompts

- In some cases, soon-to-be parents are eligible for programs before the baby is born. Has anyone talked with you about this?
- Are you aware of your rights as a parent?
- Do you feel you have the information and resources you need to prepare for the baby's birth?
- Being listed as the father on the baby's birth certificate has a lot of implications. Have you talked about a plan with the baby's mother?

- Are you receiving any support such as WIC, SNAP, TANF, housing assistance, or energy assistance? If not, have you checked to see if you are eligible?
- How have you been handling the newborn/infant phase?
- What arrangements do you have regarding the custody of the baby? Do you need legal support to navigate that conversation with the mother?

- What public assistance have you received since becoming a parent? If none, have you checked to see if you are eligible?
- What, if any, support have you received as a father?
- What is your current childcare situation? How is it working? What would an ideal situation look like?

Educational and Employment

Example pregnancy, birth, postpartum and parenting topics

Employee parenting benefits	Work/school schedule	Education goals
School/work experience	Career aspirations	Barriers to meeting goals
	Child support	

Example Prompts

- What are your education or employment goals now that you are expecting a baby?
- Who can you talk with about child support and your legal rights and obligations?
- Have you looked into any resources your job or school has for parents? (e.g., daycares, excused absences, paid leave etc.)

- Has your time spent at work or school changed since your child was born? What is your next step for staying on track with work and/or school?
- How are managing the financial responsibilities of caring for your child?

- What is your current or most recent work experience? How about education?
- Do you have specific career or educational plans or goals?
- Are you aware of the supports available through your school or job for parents?
- How have you found balancing parenting and working/pursuing education? What kinds of support or services would help improve that balance?

Additional Practice Resources and Tools

Young fathers do not have universal contexts and experiences. As youth-supporting professionals engage with young fathers, the following research-informed resources can further increase their knowledge and understanding of young fathers' specific needs.

- Casey Family Programs. What are some strategies for engaging fathers in child welfare?
- Zero to Three. Helping Young Fathers Across the Transition to Parenthood: A Rock or a Rolling Stone?
- Center for the Study of Social Policy. Changing Systems & Practice to Improve Outcomes for Young Fathers, Their Children, & Their Families
- National Responsible Fatherhood Clearinghouse. Responsible Fatherhood Toolkit: Resources from the Field
- Office of Adolescent Health. Resources for Serving Young Fathers

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Module 5: Sexual and Reproductive Health Care

What's Inside? Resources include guidance to help professionals support young people's understanding of contraception options, identify barriers to sexual and reproductive health care, and connect young people to accessible, youth-centered services.

Contents

Research on:

- Social determinants of health
- Access to sexual and reproductive health care

Tools for supporting access to care

- Engaging young people in sensitive conversations
- Identifying unmet sexual and reproductive health needs
- Connecting young people to providers and services

Contraception resources

- Overview of options
- Birth control methods matrix

Practical tools

- Actionable tips
- Community resource mapping tool

Module 5 Navigation Matrix

Sexual and Reproductive Health Care

This matrix provides an at-a-glance overview of the resources in Module 5. Use it to quickly identify each type of resource, overlap with other module topics, and the population(s) of young people emphasized. Click a resource title below to jump directly to that resource!

Resource Title	Topic Overlap:		Young People Experiencing...
Incorporating Social Determinants of Health in Practice to Address Sexual and Reproductive Health for Young People Involved in Foster Care	✓		✓ Child Welfare System
Practice Tips for Professionals Who Support Youth in Foster Care			
6 Tips for Youth-Supporting Professionals for Talking with Youth About Sexual and Reproductive Health			✓ Child Welfare System ✓ Justice System ✓ Homelessness ✓ Disconnection
Seven Dimensions of Access to Sexual and Reproductive Health Care for Youth			
Identifying Accessible Sexual and Reproductive Health Resources in Your Community			
Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth-Supporting Professionals		✓	

Resource Types: Research Summary | Tip Sheet | Practice Guide

Topics: Healthy Relationships | Violence Prevention & Intervention | Pregnancy & Parenting | Sexual & Reproductive Health Care

Incorporating the Social Determinants of Health in Practice to Address Sexual and Reproductive Health for Young People Involved in Foster Care

Rachel Rosenberg, Nia-Simone Woods, Karlee Naylon, and Julia Tallant

Introduction

This brief aims to provide child welfare practice professionals (e.g., caseworkers) information about the societal conditions that influence young peoples' sexual and reproductive health—the "social determinants of health"—and offer them guidance on incorporating this knowledge in daily practice.

Social determinants of health are the social, economic, and environmental conditions present in communities where people live, work, and gather.[1,2] Social determinants of health cover five key areas:

1. Neighborhood and built environment
2. Education access and quality
3. Health care access and quality
4. Economic stability
5. Social and community contexts

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While these conditions can affect young people's sexual and reproductive health experiences and access to prevention services in all communities,[3] social determinants of health may be amplified for young people in foster care.[4] For example, young people in foster care may miss school-based pregnancy prevention and other sexual health-related education due to placement changes and removal from their family of origin before these conversations occur. Adults within the foster care system (e.g., caseworkers, group home staff, residential care staff, court appointed special advocates (CASAs)) and parents (biological, kinship, foster, adoptive) may vary in their comfort levels with directly and openly addressing sexual and reproductive health.[5]

Research finds that sexual and reproductive health outcomes among young people in foster care are worse than among the general population (for example, young people in foster care report first having sex at younger ages than the general population, and young women in foster care experience higher rates of teen pregnancy).[6] However, research also shows that understanding and addressing the ways in which social determinants of health influence teen pregnancy and the sexual and reproductive health of young people in foster care is imperative to providing them with effective services and improving outcomes related to their sexual and reproductive health. Youth in foster care experience unique conditions that caseworkers and others working within the foster care system should be aware of and mindful toward, such as separation from family of origin, decreased social support,[7] placement instability, and lack of voice and bodily autonomy over medical decisions.[8]

In this resource, we define each social determinant of health and describe how it connects to sexual and reproductive health. Then, we discuss how each determinant relates specifically to the sexual and reproductive health and health care experiences of young people involved in foster care; this includes young people in out-of-home care and transitioning out of foster care and into adulthood. Last, we provide practice tips for foster care caseworkers to help address barriers related to each social determinant of health. The practice tips for addressing social determinants of health related to sexual and reproductive health are informed by research and by interviews the project team conducted with youth who have foster care experience and youth-supporting professionals.[a] We also encourage youth-supporting professionals to think about other factors that may influence access to sexual and reproductive health, such as local or state policies (e.g., school district policies on sexual health education) that may introduce further barriers to addressing social determinants of sexual and reproductive health among young people in foster care.

Figure 1. Social determinants of health

Five Social Determinants of Health

Neighborhood and built environment

Social determinants of health in the neighborhood and built environment refer to the ways in which a person's neighborhood, community, and environment are associated with their health.[9] These determinants include housing quality and segregation, availability of safe recreational spaces, access to transportation, access to healthy foods, air and water quality, and levels of neighborhood crime and violence.

Connection to sexual and reproductive health

Adolescents living in "distressed" neighborhoods (i.e., those that are characterized by high poverty rates, vandalism, and other environmental stressors) experience disproportionately higher rates of sexually transmitted infections (STIs) and unintended pregnancies and lower rates of contraceptive use, and are more likely to become sexually active at younger ages.[10]

Application to foster care

The impacts of distressed neighborhoods and built environments on sexual and reproductive health are compounded for youth in foster care. Youth in foster care face barriers to accessing high-quality reproductive health care to prevent or address STIs and unintended pregnancies, accessing contraceptives, and receiving supportive care. Barriers include a lack of community-based resources, limited access to clinical resources and staff members to support sexual and reproductive health, and lack of peer support programs that are trauma-informed and equipped to help young people in foster care work through complex reproductive health issues (such as pregnancy and parenting while in care, and recovering from sexual assault or trauma).[11]

[a] The project team conducted two interviews with youth with foster care experience and six interviews with youth-supporting professionals (e.g., an independent living specialist, sexual and reproductive health educators, and other direct service practitioners) focused on social determinants of health, sexual and reproductive health care, and how to navigate these factors within the foster care system. All interviews lasted 30 minutes to 1 hour and were conducted virtually via Microsoft Teams.

Education access and quality

Education access and quality as a social determinant of health refers to the ways in which education is associated with one's health and includes factors such as high school graduation, overall educational attainment, literacy levels, and access to early childhood education and development.[12]

Connection to sexual and reproductive health

Education access and quality is particularly important for adolescent sexual and reproductive health. Schools are the settings in which youth are equipped with literacy and critical thinking skills important for making decisions about their health and well-being; sexual health education focused on topics such as reducing risky sexual behaviors, preventing pregnancy and STIs, and navigating sexual development is often provided in middle and high school settings.[13,14] Furthermore, the comprehensiveness of a young person's sexual health education is associated with their sexual and reproductive health outcomes.[15]

Application to foster care

Barriers to education access and quality are exacerbated by involvement in foster care. These barriers directly influence the sexual and reproductive health of young people in foster care, who may be removed from their family of origin and their community school. These youth may also experience multiple placements while in foster care. Removal from family and community and placement instability can result in school instability, which can lead, in turn, to lower educational attainment.[16] Given that higher educational attainment is associated with lower risky sexual behavior (e.g., sex at a young age, unprotected sex), all young people should have opportunities to complete high school and pursue post-secondary training.[17] Professionals who work with youth in foster care state that youth often have knowledge gaps related to sexual and reproductive health,[18] which may be driven by a lack of access to stable education.

Health care access and quality

Health care access and quality refers to the combination of access to, experiences with, and utilization of health care services and is associated with factors such as health insurance coverage, availability of providers in an area, previous treatment by health care providers, and health literacy.[19] By asking young people about these topics, instead of assuming what their answers will be, providers can have open and honest conversations with youth.

Connection to sexual and reproductive health

Young people experience health insurance coverage gaps,[20-22] potentially related to inconsistent information provided to them about navigating the health care system. When young people are unable to use medical insurance, they may not have a primary care physician or other medical provider with whom they feel comfortable and safe discussing sexual and reproductive health. Further, state policies vary in terms of requirements for adult consent for youths' sexual and reproductive health care.

Application to foster care

Young people in foster care may experience limited access to health care, including sexual and reproductive health care—and especially high-quality health care. For example, although federal law allows youth who have aged out of foster care to access Medicaid until they are 26, the implementation of the law varies among states.[23,24] Caseworkers and other youth-supporting professionals must understand their states' consent policies. Then, they should tell young people about the services that do and do not require consent from an adult and help them determine which adult is able to provide consent. Finally, medical providers may not provide trauma-informed care, which can be triggering or inflict further emotional harm for young people in foster care due to previous traumatic experiences.[25]

Economic stability

The economic stability social determinant considers the connection between one's health and one's financial resources, including employment, housing stability, and socioeconomic status.[26]

Connection to sexual and reproductive health

Economic stability and employment are connected to sexual and reproductive health through access to health insurance and the ability to afford necessary health care in the United States. While some employers provide health insurance to employees and their families, others do not, creating differences in who has access to affordable sexual and reproductive health care.[27] Housing stability is also associated with access to health insurance—and with access to, and selection of, birth control methods—which can limit access to sexual and reproductive health care and impede family planning efforts.[28] Furthermore, individuals living in poverty or who have lower levels of socioeconomic status experience additional barriers to accessing sexual and reproductive health. Low-income communities often lack access to comprehensive sexual health education, receive misinformation about contraceptive options, have limited access to medical providers, and have limited access to abortions/information about abortions.[29]

Application to foster care

Young people in foster care are more likely to experience economic instability than their peers who are not in foster care. Findings from the California Youth Transitions to Adulthood Study indicate that 59 percent of youth transitioning from foster care earned below the federal poverty level, compared to 46 percent of youth in the general population.[30] Economic instability among youth in foster care makes it difficult for them to consistently access medical care and health insurance for coverage of services.[31] Importantly, economic instability can increase risk for participation in systems of sexual exploitation (e.g., sex trafficking or sex work) among young people in foster care, who already experience an increased risk for sexual exploitation compared to their peers in the general population.[32]

Social and community context

The social determinants related to social and community context refer to how characteristics like social connection and support, and incarceration impact health.[33]

Connection to sexual and reproductive health

Highly connected social networks that have appropriate, accurate, and relevant information can positively influence sexual and reproductive health outcomes (e.g., networks of individuals who practice safe sex may influence individuals to also have safe sex).[34] Sexual health programs that promote social connectedness with peers, family, and partners are positively associated with sexual and reproductive health by delaying age of first sexual activity, improving contraceptive use, and reducing pregnancy rates.[35] Furthermore, the social and cultural norms within a community can influence how the community views sexual and reproductive health (e.g., positive views of comprehensive sex education and access to contraceptives), which can then impact young people's access to these services and information.[36]

Application to foster care

Young people in foster care often lack social networks and support due to placement changes, making it more difficult for them to obtain the benefits of having a strong social support network.[37]

Practice Tips for Professionals Who Support Youth in Foster Care

This resource has established the parameters for five categories of social determinants of health and described ways in which these determinants impact young people's sexual and reproductive health—especially for those in foster care. Within this context, we worked with youth-supporting professionals and youth who have experience in the foster care system to identify practice tips for navigating social determinants of health when working with youth in foster care. Each item features a general practice tip that applies across all social determinants of health, along with an example of how to apply it within specific social determinant categories.

- *General guidance:* Ensure that young people have someone to whom they feel safe speaking about sexual and reproductive health.
- *Application to health care access and quality and education access and quality:* Young people in foster care may not have the same access to high-quality sexual and reproductive health care education and services as young people not in foster care.

Caseworkers should help young people identify a medical provider or school staff member with whom they feel safe speaking about sexual and reproductive health. For example, caseworkers can help a young person identify and establish supportive adult relationships in school or establish a relationship with a trusted medical provider. Caseworkers can also provide these trusted adults with information about how to communicate about sexual and reproductive health with young people.

- *General guidance:* Tailor information to individual young people and ensure that these conversations are inclusive of different experiences.
- *Application to health care access and quality and social and community context:* Young people in foster care may experience less access to tailored sexual and reproductive health education and services and more discrimination when they receive sexual and reproductive health education and services.

Caseworkers can help young people by consistently making space for youths' input in, and ownership of, conversations about sexual and reproductive health and allowing them to control the conversation. For example, caseworkers can let young people pick the topic of the conversation, ask questions about topics of their choice, and set boundaries on what they do or don't feel comfortable disclosing.

- *General guidance:* Do not assume anything about the young person's sexual behaviors or knowledge.
- *Application to neighborhood and built environment:* Adults often make assumptions about the level of sexual activity and knowledge about sexual health behaviors among young people in foster care due to preconceptions about the young person's background.

Caseworkers can help young people by refusing to make assumptions and judgements about young peoples' sexual behaviors and knowledge. For example, caseworkers should avoid assumptions about whether young people are sexually active and instead speak with the young person to establish an understanding of their sexual experiences.

- *General guidance:* Ensure that conversations are non-punitive. Young people cannot feel worried that they will get in trouble for being honest.
- *Application to health care access and quality:* Young people in foster care experience challenges in maintaining ownership over their individual decision-making authority and agency. Due to this lack of individual autonomy, professionals often find that young people are afraid to be honest about their sexual and reproductive health and health care needs and are concerned about the potentially negative consequences of their honesty.

Caseworkers can help young people by assuring that conversations about sexual and reproductive health are not punitive and remain confidential (unless the topic requires mandated reporting) and ensuring that young people do not experience negative consequences stemming from honest conversations and attempts to seek help. For example, if a young person discloses a risky sexual behavior, caseworkers should ensure that there is not a punishment for that behavior, but rather a discussion of why that behavior could be considered risky and a review of alternative options.

- *General guidance:* Present all available options and let the young person pick what works for them, or what they're most comfortable with at that moment—even if some options conflict with the caseworker's personal beliefs.
- *Application to health care access and quality:* Young people in foster care often receive minimal information about sexual and reproductive health due, in part, to limited or interrupted access to services and education.

Caseworkers can help young people by presenting all available options (e.g., contraceptive options) and helping them select an appropriate sexual and reproductive health service and/or health aide that makes them feel most comfortable at the time. For example, caseworkers can provide guidance during discussions about the range of contraceptive options, based on youths' circumstances and interests, or connect the young person with a colleague or medical provider who is able to have such conversations.

- *General guidance:* When possible, provide resources to which young people can refer back. Be sure to vet resources provided via social media or other online sources.
- *Application to health care access and quality:* Conversations about sexual and reproductive health can often be overwhelming or sensitive. When young people can access resources for later reference, they face less pressure to remember everything that was discussed.

Caseworkers can help by cultivating a network of professionals to whom they can connect young people to ensure that youth receive relevant and helpful information. For example, a caseworker might have a pool of approved mentors or other supportive adults with varied lived experiences who have agreed to be connected with young people.

- *General guidance:* Build a broad network of professionals to connect young people within communities.
- *Application to social and community context:* Young people often have smaller social support networks and experience severed ties to supportive adults due to their system involvement.

Caseworkers can help by connecting young people to preventative care while in foster care and ensuring that sexual and reproductive health care is built into case plans and regularly discussed with young people. For example, a caseworker may indicate in a young person's case plan that they will receive preventative sexual and reproductive health care that is age-appropriate while in foster care.

- *General guidance:* Provide preventative care and conversations. Don't just reach out when something happens.
- *Application to health care access and quality:* Young people in foster care may not have consistent access to preventative health care services such as a yearly pelvic exam.

Caseworkers can help by providing transportation to appointments or providing bus passes for young people. Additionally, caseworkers should ensure that young people can afford any copays, prescriptions, or other follow-up needed to access sexual and reproductive health services. For example, a young person may not be able to attend an appointment because they do not have transportation, but a caseworker could drop them off or provide a bus pass.

- *General guidance:* Provide access to resources such as transportation or financial support for services.
- *Application to economic stability:* Young people may not have access to reliable transportation or the financial support necessary to access sexual and reproductive health services.

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Practice Tips for Professionals Who Support Youth in Foster Care

The following tips accompany our resource, *Incorporating the Social Determinants of Health in Practice to Address Sexual and Reproductive Health for Young People Involved in Foster Care*. We worked with both youth-supporting professionals and youth with lived expertise in foster care to identify practice tips for navigating the social determinants of health when working with youth in foster care. These tips cover a range of social conditions that may arise when talking to youth about pregnancy prevention and related sexual and reproductive health topics. While each general practice tip applies across all social determinants of health, we provide examples of how to apply these tips within specific social determinant categories in our full resource.

Ensure that young people have someone with whom they feel safe discussing sexual and reproductive health.

Caseworkers should help young people identify a medical provider or school staff member with whom they feel safe speaking about sexual and reproductive health.

Tailor information to individual young people and ensure that these conversations are responsive to a range of experiences.

Caseworkers can help young people by providing relevant resources and tailoring sexual and reproductive health information to individual young peoples' needs, experiences, and communities.

Always make space for youths' input and let them drive the conversation.

Caseworkers can help young people by consistently making space for youths' input in, and ownership of, conversations about sexual and reproductive health and allowing them to control the conversation.

Figure 1. Social determinants of health

Do not assume anything about the young person's sexual behaviors or knowledge.

Caseworkers can help young people by refusing to make assumptions and judgements about young people's sexual behaviors and knowledge.

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Ensure that conversations are non-punitive. Young people cannot feel worried that they will get in trouble for being honest.

Caseworkers can help young people by assuring that conversations about sexual and reproductive health are not punitive and remain confidential (unless the topic requires mandated reporting) and ensuring that young people do not experience negative consequences stemming from honest conversations and attempts to seek help.

Present all available options and let the young person pick what works for them, or what they're most comfortable with at that moment—even if some options conflict with the caseworker's personal beliefs.

Caseworkers can help young people by presenting all available options (e.g., contraceptive options) and helping them select an appropriately tailored sexual and reproductive health service and/or health aide that makes them feel most comfortable at the time.

Ensure that conversations are held in the young person's preferred language and address language barriers (e.g., offer resources and handouts in the young person's preferred language, hire an interpreter).

Caseworkers can help by ensuring that young people have access to interpreters or staff skilled in a range of languages to engage in conversations.

Build a broad network of professionals to connect young people within communities.

Caseworkers can help by cultivating a network of professionals with whom young people can connect to ensure that youth receive relevant and helpful information.

Provide preventative care and conversations. Don't just reach out when something happens.

Caseworkers can help by connecting young people to preventative care while in foster care and ensuring that sexual and reproductive health care is built into case plans and discussed with young people.

Provide access to resources such as transportation or financial support for services.

Caseworkers can help by providing transportation to appointments or providing bus passes for young people. Additionally, caseworkers should ensure that young people can afford any co-pays, prescriptions, or other follow-up needed to access sexual and reproductive health services.

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ACTIVATE

Six Tips for Youth-Supporting Professionals for Talking with Youth about Sexual and Reproductive Health

Introduction

Youth-supporting professionals can play a critical role in educating youth about sexual health. For example, professionals can support young people in developing the skills they need to safely negotiate sexual encounters.[1] When professionals approach conversations with youth about sexual and reproductive health openly and honestly, they can build and maintain a rapport with young people.

This tip sheet provides youth-supporting professionals with six tangible recommendations to promote effective and open conversations about sexual and reproductive health with young people, especially youth who are in the child welfare or juvenile justice systems or who are experiencing homelessness or disconnection from work and school (also referred to as opportunity youth).

These tips were developed through a series of discussion sessions with five youth who have been involved in the child welfare or juvenile justice systems or who have experienced homelessness or disconnection, and four youth-supporting professionals. Activate researchers identified relevant literature to support the themes that emerged from those discussions. Whenever possible, that research focused on youth in the child welfare or juvenile justice systems, youth experiencing homelessness, or opportunity youth.

These tips are based on two assumptions about the role of professionals in communicating with youth about sexual and reproductive health:

1. Youth-supporting professionals have conversations with young people about sexual and reproductive health. The recommendations in this tip sheet are meant to facilitate those conversations.
2. Youth-supporting professionals must acknowledge when they do not have answers to youths' questions and seek needed information in partnership with the youth. Youth-supporting professionals should avoid trying to "know everything" when discussing sexual and reproductive health with youth.

Youth-supporting professionals and youth identified the following six tips:

Nº 1

Be Comprehensive and Clear in Discussions about Sexual and Reproductive Health

Both youth and professionals who support them identified a need for sexual and reproductive health education to include more concrete, real-world practical guidance. For example, youth wished they had learned what to expect when they get their period, how to use condoms, and which forms of contraception have what side effects. Several youth who experienced a pregnancy noted that professionals failed to provide them with relevant sexual and reproductive health

information, such as how to have a healthy pregnancy and what to expect while pregnant.

To be clear and comprehensive:

- Ask youth what they want to discuss and provide resources on a variety of topics to prompt discussion.[2]
- Help youth develop functional and assertive communication skills, for example, role-play conversations about contraception with a partner.[3]
- Use a trauma-informed, youth-centered approach that takes into consideration the circumstances and life experiences (e.g., experience in healthy relationships, intimate partner violence, and sexual abuse) that may impact a young person's sexual and reproductive health, the options available to them, and the decisions they make.[2]
- Understand that the knowledge youth have and the information they need may be different, depending on characteristics and their identity such as their sex, age, intellectual abilities, and past experiences. For example, youth in the juvenile justice and child welfare systems may not have received formal or informal sexual health education due to placement instability and changes in schools and healthcare providers. Youth who experience such instability may need more information from youth-supporting professionals than youth who have not been involved in these systems.[3,4]

№ 2

Explain Confidentiality and Reporting Requirements

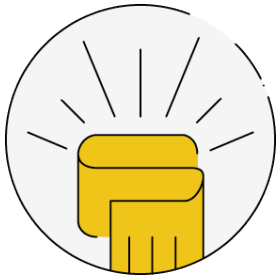
Concerns about confidentiality and reporting requirements can be barriers to discussing sensitive topics (e.g., sexual and reproductive health, intimate partner violence, child abuse/neglect).[5-7] Although confidentiality and reporting requirements are complex and vary across professions, settings, states, and other circumstances, youth-supporting professionals should be familiar with their legal obligations and clearly discuss reporting requirements with youth.

Youth-supporting professionals may be hesitant to initiate conversations about sensitive topics because they are unsure about their legal obligations and legal protections for youth. Meanwhile, youth may be hesitant to disclose information because they don't know if that information will be reported.[9] Research shows that youth who said they talked about confidentiality with a youth-supporting professional were more likely to discuss sensitive topics than youth who did not talk about confidentiality with a youth-supporting professional.[8]

When discussing confidentiality and reporting with youth:

- Be specific about the limits to confidentiality, reporting requirements, and what happens after a report is made. Talk to youth about what does and does not have to be reported, who it needs to be reported to, who might have access to it, and how it will be protected. Explain the reporting process and the procedures for responding to a report, so youth know what to expect if a report is made.[9]
- Talk to youth about confidentiality early and often, so youth feel comfortable discussing sensitive topics. Have a conversation about confidentiality first before any other conversation occurs. During sensitive discussions, remind youth of confidentiality limits before or when they are disclosing potentially reportable information. Talking to youth about confidentiality may make them more likely to discuss sensitive topics in the future.[8]

- Have a clear understanding of organizational mandates and state laws and reporting requirements that govern your professional work and clearly explain them to youth. Become familiar with reporting procedures and what happens after a report is made (e.g., What happens after making a report of child abuse/neglect, rape, or intimate partner violence?). Youth-supporting professionals should review profession-specific codes of ethics, requirements based on practice setting (e.g., health care, juvenile justice facility, residential child welfare facility), and state-specific regulations.



Nº 3

Customize Interactions with Youth Based on Context and Individual Needs

Youth-supporting professionals should consider the experiences of youth while remaining judgement-free and open for redirection (e.g., letting the youth guide the conversation).[1,10] Youth-supporting professionals should take the contexts of youths' lives into account and talk to them about factors that influence their sexual and reproductive health, such as healthy relationships, consent, and communicating with partners about condoms and contraception.[1,11,12]

To tailor your interactions with youth:

- Talk to youth about the contextual factors that may affect the decisions they make about their sexual and reproductive health, such as experience with healthy relationships, intimate partner violence, trauma, and messages they have received about sex from peers and others in their lives.[1,13,14]
- Build trust, so youth feel more comfortable having conversations about sensitive topics or sharing information about themselves.[5]
- Ask direct questions, especially about human trafficking and other risk factors, such as drug use or sexual abuse. Doing so can be effective in reducing shame, discomfort, and guilt for the youth and help continue to build the foundation for discussion and disclosure.[14,15]
- Avoid making assumptions about youths' experiences (e.g., whether they have been sexually active) and knowledge (e.g., whether they know how to use a condom correctly).
- Acknowledge one's lack/gaps in knowledge and turn these gaps into a joint learning opportunity for you and the youth.[16] This also helps youth learn to find reliable sources of information when needed.
- Avoid using phrases that downplay or trivialize, how youth are feeling, such as "You will understand when you are older." Such phrases may discourage youth from talking about sensitive, but important, topics in the future.[20]
- Avoid overgeneralizations that youth may perceive as judgmental, such as "Gen Z-ers are always on their phone."[20]

Honor and Respect Youth Requests and Decision-Making

Youth are more receptive to sexual and reproductive health education when they feel respected and when their unique needs are met.[17] Youth want to share their thoughts with, ask questions of, and be heard and valued by youth-supporting professionals.[18]

№ 4 When having conversations, youth-supporting professionals should:

- Honor and respect youths' decision-making autonomy.[4,7] It is developmentally appropriate for youth to play an active role in their healthcare decisions. Youth have individual needs and desires that professionals must take into account when working with youth. For example, provide information about all forms of birth control, and let youth choose what they want to use.
- Be self-aware and avoid letting personal values and beliefs get in the way of addressing youth needs.[4,11] For example, a professional who believes young people should not engage in sexual activities should provide a young person asking about birth control with the medically accurate information and linkages to care needed to make an informed decision.
- Talk with youth and not *at* youth.[7,20] Create and make space for youth to participate in conversations, acknowledge their requests, and support them in making their own decisions, rather than lecturing youth about what they should or should not be doing.
- Meet youth where they are and provide the information they request.[26] Tailor information to the youth's knowledge, experience, and age. Be prepared for unanticipated conversations and be ready to provide information in different formats (e.g., visual, auditory), and on multiple occasions.
- Use active listening to identify what the youth needs, and provide resources that meet those needs (e.g., provide medically accurate information on all forms of birth control and let the youth decide instead of encouraging one specific birth control).[3,20]
- Respect the family planning wishes of youth, including youth who communicate wanting to become pregnant and start a family.[21] Youth-supporting professionals should honor the youth's wishes for starting a family and when they would like to do so. Many youth reported not receiving information or support when they communicated that they wanted to become pregnant and start a family. Other youth reported not receiving information about all the forms of pregnancy prevention. It is important to give youth all the information so they can make an informed decision.

Use Positive Mannerisms and Body Language

Youth-supporting professionals should pay attention to verbal and non-verbal communication styles when talking about sexual and reproductive health. This includes being aware of body language, tone, mannerisms, and facial expressions.[22]

Nº 5

To create an open conversation with youth:

- Pay close attention to tone of voice, including vocal pitch.[22] Use a moderate tone of voice (i.e., not too loud or too soft) to convey warmth and self-confidence; use a neutral tone of voice to avoid sounding irritated or dismissive.[16]
- Be mindful of facial expressions.[22] Smiling communicates positivity and helpfulness while eye contact can also communicate confidence. Maintaining eye contact communicates attention and interest in what another person is saying.[22] Together, these kinds of facial expressions communicate active listening and can encourage youth to speak openly and honestly about sexual and reproductive health.
- Avoid reactions that communicate negative emotions, such as disgust (e.g., furrowed eyebrows, wrinkling your nose, raised lip), or concern (e.g., raised eyebrows, wrinkled forehead, and open mouth), by taking a deep breath before reacting.[22]
- Ask questions in a non-judgmental manner. Avoid starting questions with a statement followed by a question such as, “sex at a young age can be risky. Are you sexually active?” Instead, just ask “are you sexually active?” Avoid changing your tone of voice or communicating judgement through body language (e.g., crossing your arms, not making eye contact, or not facing the youth).
- Use positive mannerisms such as head nods and speaking slowly without rushing to indicate active listening and encourage the youth to keep talking.[1]

Build Safe Physical and Emotional Environments (in-person and virtually)

Youth and youth-supporting professionals said safe physical and emotional environments are essential to open and honest conversations about sexual and reproductive health.[1, 18]

Nº 6

To create a safe physical and emotional environment both in-person and virtually:

- Build a trusting relationship with youth before discussing sexual and reproductive health in-person or virtually.[1]

- Ensure a clean and organized space that smells fresh by using a candle or essential oil diffuser.[23] If creating a virtual space, ensure the space within the camera angle is tidy and try to minimize distractions. Include welcoming art in the space.
- Ensure the space is private and accessible. In-person spaces should be private with minimal risk for others to overhear. Spaces should be accessible to youth with different abilities.
- Include comfortable furniture with a variety of options, such as comfortable chairs, beanbag cushions, and a blanket or a weighted blanket.[17]
- Have information readily available in the space for youth to read and take with them or create virtual information that can be easily emailed and downloaded.[24]
- Create group norms,[25] encourage confidentiality, discuss limitations, and build trust among the group before discussing sexual and reproductive health in a group setting (in-person or virtually). Ensure youth in the group feel comfortable.

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Seven Dimensions of Access to Sexual and Reproductive Health Care for Youth

Asari Offiong, Julia Tallant, Katelyn Rust, Abigail Wulah, and Lee Ann Huang

Overview

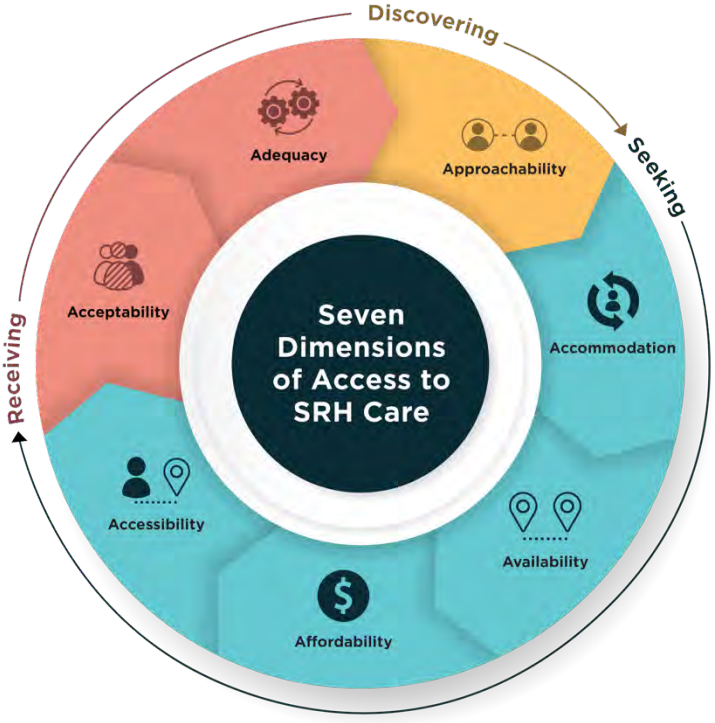
This brief summarizes available research on seven dimensions of access to sexual and reproductive health care. Our goal is to inform youth-supporting professionals about the complexity of access for youth who have experienced the child welfare and/ or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth). Understanding the dimensions of access is critical to supporting the sexual health of—and preventing unintended pregnancy among—young people with these experiences.

Below are the key takeaways from this brief.

- There are three phases of access to sexual and reproductive health care—discovering, seeking, and receiving—which are comprised of seven dimensions that further explain whether and how youth access sexual and reproductive health care.
- Understanding the seven dimensions of access can help youth-supporting professionals increase access to sexual and reproductive health care services among the youth they serve.
- Research and resources specific to youth who have experienced the child welfare and/or justice systems, homelessness, and disconnection from work/school are limited.
- Changing contexts make it difficult to track current policies and their impacts on access to sexual and reproductive health care among youth.

We begin with background information on why access to sexual and reproductive health care is important for youth who have experienced the child welfare and/or justice systems, homelessness, and/or disconnection from school and work. Next, we define the seven dimensions of access, drawing upon two conceptual frameworks, and describe our methods for developing the research summary. Then, we

Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth- Supporting Professionals *bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/ or disconnection from school and work (i.e., opportunity youth).*



discuss each dimension and related literature from the past five years. Last, we consider and reflect on practice implications for youth-supporting professionals. The contents of this research summary are relevant to youth-supporting professionals who want to increase access to sexual and reproductive health care among these young people regardless of the setting in which they work.

Background

In the United States, an estimated 4.2 million youth and young adults experience homelessness each year,[1] about 110,000 youth and young adults ages 13 and older are in foster care on a single day,[2] nearly 25,000 youth are held daily in a juvenile justice facility,[3-5] and 4.7 million youth ages 16 to 24 are disconnected from work or school.[6] Despite their unique needs, youth with these experiences often lack access to essential health care, including sexual and reproductive health care (e.g., contraception, STI treatment, prenatal or postnatal care, etc.).[7-10] Moreover, when they do access sexual and reproductive health care, youth often report being stigmatized and judged by providers who lack empathy or whose care is not youth-centered.[11,12]

Individual, community, and system-related challenges constrain efforts to promote sexual health among young people who have experienced the child welfare and/or justice system, homelessness, and/or disconnection.[7,13-15] For example, youth involved in the child welfare or justice systems report challenges accessing condoms or sexual health information, limited knowledge about sexual health, and policies that restrict their access to sexual and reproductive health care services.[9,16,17] Barriers like these are associated with increased sexual risk-taking (i.e., unprotected sex, early sexual debut), unintended pregnancies, STI transmission, and less frequent receipt of prenatal and postpartum care relative to their peers.[18-21] Providing access to sexual and reproductive health care includes educating youth to inform their decision making, equipping them with resources to make informed decisions, and providing them with trauma-informed services tailored to their unique needs. Access to sexual and reproductive health care can help young people avoid unintended teen pregnancy.

Findings

Seven dimensions of access to sexual and reproductive health care

We conceptualize access to sexual and reproductive health care using seven overlapping and interconnected dimensions (Table 1), organized into three phases: discovering, seeking, and receiving. During the **discovering phase**, young people must be *aware* that a service or provider exists to meet their needs. During the **seeking phase**, young people consider whether the provider *accommodates* their individual needs, whether the services they need are *available* and *affordable*, and whether the physical location of the provider is *accessible*. During the **receiving phase,** young people focus on the quality of care offered and whether their provider considers their individual background and experiences. Thinking about these three phases of access may help professionals support and increase young people's access to sexual and reproductive health care.

These dimensions are drawn and adapted from two conceptual frameworks related to health care access. The first was published by Penchansky and Thomas in 1981[22] and the second was published by Levesque and colleagues in 2013.[23] The frameworks conceptualize access as multi-dimensional—a function of the fit between the characteristics of health care providers and the characteristics of health care users. Many of the dimensions overlap, but there are instances where new dimensions were identified in the later framework developed by Levesque.

Table 1. Seven Dimensions of Access to Sexual and Reproductive Health Care: Definitions and Examples

	Dimension	Definition	Example	
			Facilitator	**Barrier**
Discovering	Approachability	Extent to which health care providers make young people aware of their existence	A clinic does targeted outreach to youth experiencing homelessness through a street outreach program using peer educators.	No mention of youth- specific services on the provider's website or written materials.
Seeking	Accommodation	Extent to which health care providers consider young people's needs and preferences, as well as the constraints that limit their options	A clinic is open until 7:00 pm on weeknights and from 9:00 am to 4:00 pm on Saturdays for youth.	The clinic is by appointment only with limited hours.
	Availability	Extent to which providers offer the health care services youth need	A school-based health center provides sexual and reproductive health care services to students.	A school-based health center only provides condoms in the waiting area.
	Affordability	Extent to which the cost of health care services is aligned with the youth's ability to pay	A clinic offers a sliding scale fee for young people who are uninsured.	Youth must pay a co- pay before a service is provided.
	Accessibility	Extent to which the location of services is reachable	A clinic is centrally located with easy access to public transit.	A clinic is in a remote location only accessible by car.
Receiving	Acceptability	Extent to which health care providers recognize, consider, and honor cultural, social, and individual factors that influence care	A health care provider uses motivational interviewing to assess a youth's sexual health needs.	A health care provider develops a care plan without consulting the young person.
	Adequacy	Extent to which health care services are appropriate, timely, integrated, and continuous	A clinic offers youth care coordinators to follow-up on the visit and connect to other resources.	A young person is given a list of services with no referral or follow-up call.

Discovering

Approachability: The extent to which health care service providers make young people aware of their existence

Young people cannot access sexual and reproductive health care services of which they are not aware. Likewise, youth-supporting professionals cannot refer youth to health care services that they do not know about. Awareness requires targeted outreach efforts by health care providers to youth and the professionals who support them.[24] Young people need to know that health care services exist and can improve their health,[22] while youth-supporting professionals must have up-to-date information about health care services to which youth can be referred. One study by Beal and colleagues (2020) found that providing youth in foster care with youth-informed educational materials—including information about health care providers, sexual and reproductive health, and appropriate levels of care—increased their self- reported health care utilization.[25] Based on their interviews with service providers about access to health care among youth experiencing homelessness, Gallardo and colleagues (2020) recommended enhancing the approachability of services by intentionally identifying young people's health care needs and linking them to appropriate services.[24]

Seeking

Accommodation: The extent to which service providers consider young people's needs and preferences, as well as the constraints that limit their options for care

Health care services are often delivered in ways that are not youth-centered (i.e., a lack of consideration for school, work, or other commitments that limit availability; use of medical jargon or technical terms difficult to understand; or requiring in-person visits to be seen). For example, youth experiencing homelessness and youth in foster care may not have learned how to identify a health care provider, schedule a medical appointment, or otherwise navigate the health care system.[24,4] Lack of knowledge about their personal and family medical history can make it difficult for these young people to complete medical intake forms.[24,27] Youth experiencing homelessness may have trouble accessing health care services because many lack a state ID or proof of health insurance.[24] Limited availability of walk-in appointments, hours that conflict with young people's school or work schedules, and the lack of a primary health care provider lead many youth experiencing homelessness to rely on emergency departments for their health care.[24,28,29]

Availability: The extent to which providers offer the health care services youth need

The availability of sexual and reproductive health care is affected by policies that either mandate or restrict access.[24,30] Some policies affect youth involved in a particular system. For example, a study conducted in 2021 across 17 juvenile detention and committed centers in California, Maryland, and Georgia found variation in the services provided to pregnant youth, even though all facilities offered obstetric and gynecological care. These discrepancies resulted in differing availability of on- or off-site OB/GYNs, pregnancy testing, and abortions (including the requirement of judge approval).[31] Meanwhile, youth who are under court supervision but not incarcerated are left to address their sexual and reproductive health on their own, since they are not protected under the same mandates as those in detention facilities that require such care.[10,32]

Affordability: The extent to which the cost of services is aligned with young people's ability to pay

Health insurance coverage is a primary determinant of sexual and reproductive health care affordability, particularly for youth.[22,33] Young people are typically covered by Medicaid while they are in foster care and continue to be eligible for Medicaid until their 26th birthday if they age out of care.[25] Young people involved with the justice system may have access to sexual and reproductive health care while they are detained or incarcerated but may lack health insurance when they are living in their communities, which can result in discontinuity of care.[33,34] Young people experiencing homelessness may be covered by their parent/caregiver's insurance but may not possess proof of insurance or other important documentation needed to utilize their coverage.[35] They may also be eligible for Medicaid if they live in a state that has enacted Medicaid expansion, although several states have declined to expand Medicaid in recent years.[35,36] In 2010, the Patient Protection and Affordable Care Act expanded access to health insurance among young people and required that contraception and some preventative sexual and reproductive health services are covered by insurance; however, young people must be insured to take advantage of this.[36] The Hyde Amendment and additional state laws prohibit the use of federal funds and federally funded health care for abortion care, except in cases of rape, incest, or a life-threatening pregnancy.

Out-of-pocket expenses such as coinsurance payments, as well as transportation costs, can also limit young people's ability to access sexual and reproductive health care.[22,37] To mitigate issues related to affordability, Gallardo and colleagues found that health care providers used funds from multiple state and federal grants and collaborated across health care organizations to address the health care needs of youth experiencing homelessness.[24]

Accessibility: The extent to which the location of services is reachable

The physical location of a clinic is an important factor to consider for youth. Lack of transportation can be a barrier for youth who don't live near a clinic and rely on family or friends or public transportation to get to appointments.[38-40] Youth are also vulnerable to sudden moves to communities where sexual and reproductive health care is inaccessible, which can interrupt the continuity of their care. For example, youth in foster care may be moved from one placement to another, youth experiencing homelessness may be forced to move due to shelter stay limits, and youth in the juvenile justice system may be moved from a detention facility back into the community.[26,41-43] In addition to a clinic being centrally located or reachable by public transit, it is necessary to account for the physical safety of the environment for youth. Current research does not specifically discuss physical safety related to accessing sexual and reproductive health care, but it has been linked to whether youth decide to engage in a program or access a service of any type.[44] Although studies have shown that telehealth can increase the accessibility of sexual health services and information for adolescents,[45] a study of young people experiencing food and housing insecurity found that they perceived greater barriers to accessing contraceptives via telehealth than their peers.[46]

Receiving

Acceptability: The extent to which health care service providers recognize, consider, and honor cultural, social, and individual factors

Youth view health care as more acceptable when providers are respectful, nonjudgmental, and work to establish trust.[30,47-49] A history of trauma is common among youth experiencing homelessness, or in the child welfare and juvenile justice systems.[24] Health care providers who understand the impact of trauma on young people's behaviors may demonstrate the flexibility and open-mindedness needed in their interactions with youth to avoid retraumatizing them.[24] Confidentiality and privacy are also critical to young people's perceptions of health care acceptability.[10,31,50] Health care may be perceived as unacceptable if youth fear that a provider will notify their parent or caregiver (e.g., relative or foster parent)[14,32,51,52] or if they are required to disclose information about their sexual or reproductive health to others, such as a caseworker or attorney, as a precondition of access.[30,53] Sexual and reproductive health is a sensitive topic where youth are often met with adult disapproval, judgment, or stigma toward their decisions or questions around their sexual health.

Adequacy: The extent to which the health care services provided are appropriate, timely, integrated, and continuous

High mobility among youth experiencing homelessness reduces their likelihood of repeated encounters with the same health care provider. High mobility challenges youth who experience homelessness to maintain comprehensive medical records, coordinate care across health care settings, and/or establish strong relationships between providers and youth.[24] However, youth who experience the justice system benefit from continuity of care through integrated systems, including public health and court systems. Health care providers and youth-supporting professionals struggle to offer consistent, continuous, and coordinated care to youth who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work due to a lack of knowledge about confidentiality and Health Insurance Portability and Accountability Act (HIPAA) laws.[32] Overall, there is limited literature on the adequacy of sexual and reproductive health care services for youth across these populations.

Reflections

Our review of the literature on the seven dimensions of access to sexual and reproductive health uncovered relatively little to no research related to health care access among youth who are disconnected from school and work. While youth who are disconnected were not specifically identified in the literature, we are aware that they may overlap with other populations (i.e., youth experiencing homelessness, involved with the child welfare systems, etc.) and may be represented within those findings. In addition, access to sexual and reproductive health care is highly dependent on the state in which youth live and on the systems in which they are involved.

The literature we reviewed points to several strategies that could be implemented by health care service providers to increase access to sexual and reproductive health care for youth who have experienced the child welfare or juvenile justice systems, homelessness, or disconnection. Youth-supporting professionals outside of the clinical space could also benefit by using the dimensions to assess organizations and/or providers to which they refer young people.

Phase	Strategy to implement or identify when assessing services for youth
Discovering	Outreach efforts are targeted and use branded materials that are youth-friendly and written using plain, age-appropriate language.[31,54]
Seeking	Extended hours, walk-in appointments, and mobile services are offered. Accommodations are made to offset transportation costs, including gift cards or bus/public transit tokens.[15,46] Health care service costs, payment options, and types of health insurance accepted are stated upfront. Communications for youth consider disabilities and/or language barriers.[55-58]
Receiving	Confidentiality is emphasized to youth, including explanation of state policies, their rights, and how confidentiality is maintained in a clinic setting.[59] Continuity of care is considered, including the provision of care navigators, co-location of health care services with other social services, and interagency partnerships to facilitate health care linkages.[24,60]

Methods

With input from five youth-supporting professionals and two youth advisors, we adapted the definitions for each of the dimensions to be more relevant to young people. Then, we used Google Scholar and PubMed to search for peer-reviewed and grey literature published from 2018 to 2023. We limited our search to these five years because access to sexual and reproductive health care has been affected by recent changes in policies and the political climate. We used search terms related to each of the seven dimensions that included specific youth populations: youth in the child welfare or juvenile justice systems, experiencing homelessness, or disconnected from school and work. Our search identified 62 peer- reviewed articles and 17 resources, which we reviewed, coded, and summarized in a spreadsheet. Equity and content reviews were completed by members of Activate's Research Alliance to ensure the accuracy, relevance, and appropriateness of our research synthesis.

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About the Authors

Asari Offiong, PhD, MPH is a senior research scientist at Child Trends and a member of Activate's Need Assessment and Research Translation Teams.

Julia Tallant is a research analyst at Child Trends and a member of Activate's Need Assessment and Research Translation Teams.

Katelyn Rust is a senior community liaison at Child Trends and a member of Activate's project team.

Abigail Wulah, MSPH is a research analyst at Child Trends and a member of Activate's Research Translation Team.

Lee Ann Huang, MPP is a researcher at Chapin Hall and a member of Activate's Research Translation Team.

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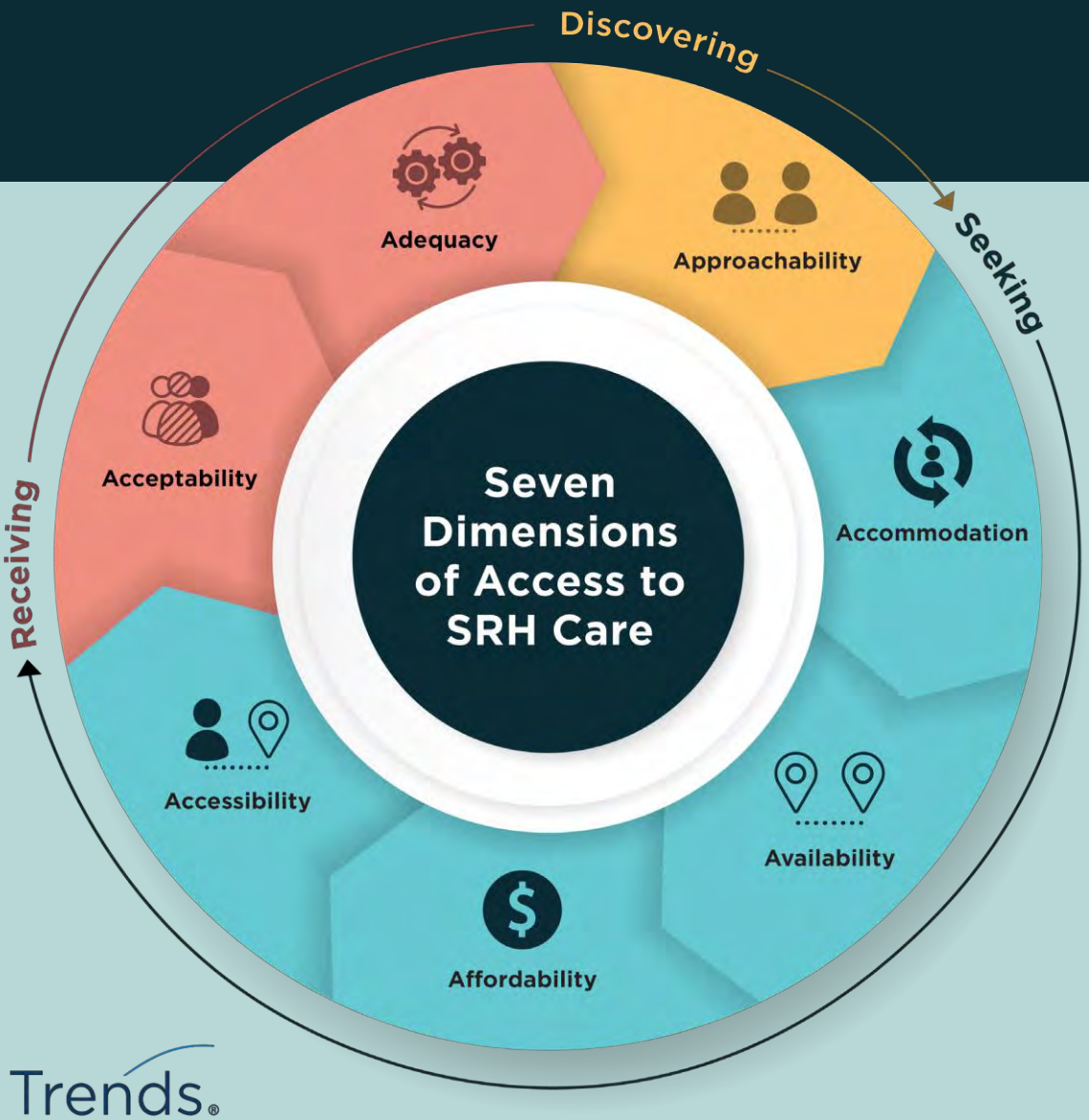
Child Trends

CHAPIN HALL

ACTIVATE | A partnership between Child Trends & Chapin Hall

Identifying Accessible Sexual and Reproductive Health Resources in Your Community

Asari Offiong, Lee Ann Huang, Maia Pruim, Abigail Wulah, Katelyn Rust, and Julia Tallant



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CHAPIN HALL

Introduction

Identifying Accessible Sexual and Reproductive Health Resources in Your Community is a tool to help you, as youth-supporting professionals, scan the landscape of sexual and reproductive health care providers for teens and youth. When you know the landscape, you can intentionally refer youth to providers who meet their individual needs. The information in this tool is based on a research summary from Activate*: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals, which describes seven dimensions of access to sexual and reproductive health care.[a]

This landscape scan tool walks through the seven dimensions of access to sexual and reproductive health care. You will engage with questions and research-based examples about each dimension of access, a guided opportunity to reflect on your answers, and potential strategies to consider your next steps. You will begin to ***critically determine how to address barriers and facilitators*** to accessing sexual and reproductive health care for youth who have diverse needs.

**Activate: The Center to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals* bridges the gap between research and practice in support of the Office of Population Affairs' aims to promote adolescent health and prevent unintended teen pregnancy. Activate translates research and creates research-based resources for use by professionals who support young people experiencing the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).

Lack of access to sexual and reproductive health care and education can lead to greater risks to health and other negative outcomes.[1,2] Youth who have experience with the child welfare and/or justice systems, homelessness, and/or disconnection from school and work face additional barriers in access to care[3–5] due to limited access to health education and public systems that may restrict how and when they can receive sexual and reproductive health care services.[6]

How to use this tool

1. **Identify providers in your community:** Use online searches and/or your network to compile a list of sexual and reproductive health care service providers in your community (e.g., clinics, school-based health centers, hospitals). The list might include providers to whom you already refer youth for sexual and reproductive health care services and/or providers to whom you would like to begin referring youth.

2. **Complete the worksheet**: Complete *Section A: Exploring the Seven Dimensions* of this worksheet for each sexual and reproductive health care service provider on your list that serves youth. For some of the questions, you may not know the answers—which is acceptable. Based on your responses to the guiding questions provided, select the option that best represents your assessment of the provider's capacity to provide accessible care.

3. **Review and reflect:** Review and reflect on your assessment using *Section B: Reflecting on the Seven Dimensions*. Some of the dimensions may be more critical than others to the youth you serve. You may need to gather additional information on certain dimensions to better assess the questions for a comprehensive understanding. On a periodic basis, update your understanding and reflect on each provider individually and the collective network of providers in your community.

4. **Consider next steps:** Consider the strategies in *Section C: Applying Next Steps* to guide your next steps.

[a] Each of the examples used to illustrate the dimensions is based on this research summary. At the end, there is a full list of references provided.

Section A. Exploring the Seven Dimensions

Answer the guiding questions for each dimension of access. Based on your overall knowledge, indicate for each dimension whether you believe the provider (A) is weak, (B) you are unsure, or (C) is strong.

Name of Provider/Organization: _____ **Location:** _____

Approachability

1. Is it clear that youth are involved in their marketing and outreach plan?
2. Do the services and/or resources appear relatable or relevant to what youth need?
3. Are youth you work with aware of/familiar with the service/provider?
4. Are youth engaged and hands-on in the design or delivery of services?

Website does not mention serving youth or offering youth-specific services — *Youth ambassadors promote the services on social media and in the community*

A. Weak **B. Unsure** **C. Strong**

Accommodation

1. Are the hours convenient for youth?
2. Are same-day or walk-in appointments available?
3. Is telehealth an option?
4. Does the provider offer help with filling out medical forms?

Clinic only has weekday hours, requires an appointment, and telehealth is not an option — *Clinic has evening and weekend hours, allows for walk-ins, and offers telehealth appointments*

A. Weak **B. Unsure** **C. Strong**

Availability

1. Does the provider offer all the sexual and reproductive care services the youth you serve might need, including health education, counseling, contraceptives, STI prevention and treatment, and abortion?

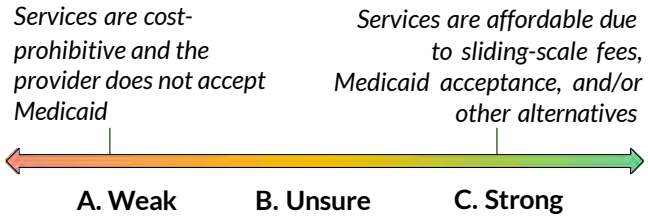
2. Does the provider offer support for expectant and parenting youth including prenatal, labor and delivery, and/or postpartum care?

Clinic only provides limited contraception options — *Clinic offers a full array of sexual and reproductive care options including all types of contraceptives and pregnancy care*

A. Weak **B. Unsure** **C. Strong**

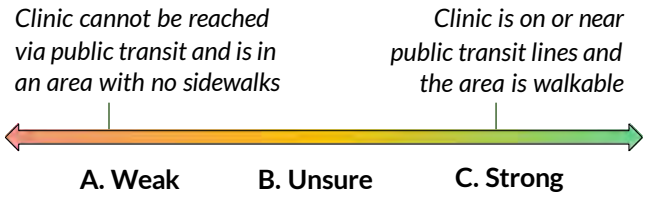
Affordability

1. Does the provider offer free or low-cost care?
2. Does the provider accept Medicaid?
3. Will the provider help youth identify ways to pay for care (e.g., Medicaid or insurance) and help them enroll in or use those mechanisms?



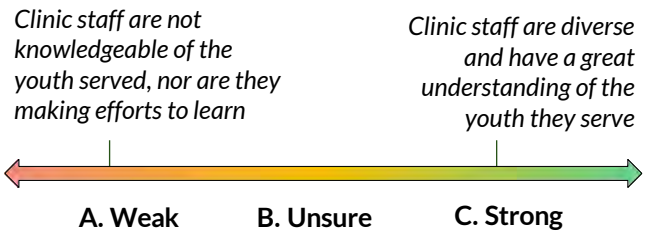
Accessibility

1. Is the facility easy to reach by car, public transportation, or walking?
2. Are the facility and the surrounding area safe?
3. Is the facility accessible for youth with mobility or other disabilities?



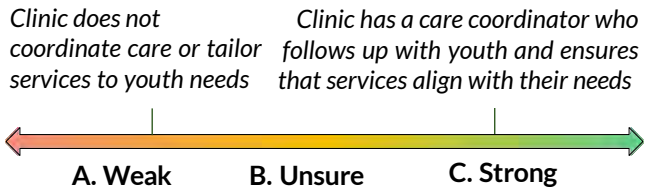
Acceptability

1. Does the diversity of the staff represent the intersecting identities and experiences of youth you serve?
2. Is the environment safe for all youth?
3. Is the provider flexible, knowledgeable, and willing to adjust to the beliefs and norms of the youth you serve?
4. Does the provider apply trauma-informed approaches, such as sensitivity to safety, choice, respect, trustworthiness, empowerment, and peer support?



Adequacy

1. Does the provider take a holistic approach to servicing youth by providing comprehensive care that considers all their needs?
2. Is the provider timely in following up with youth after appointments?
3. Is the clinic well connected to other youth-friendly services and/or providers?
4. Does the clinic coordinate care across settings?



Section B. Reflecting on the Seven Dimensions

Fill in the table below with your responses for each of the dimensions in Section A.

Dimension of Access	Response (Weak, Unsure, or Strong)
Approachability	
Accommodation	
Availability	
Affordability	
Accessibility	
Acceptability	
Adequacy	

Take a moment to review your responses carefully. To guide your reflection of the responses, walk through these questions on your own or with your colleagues.

- What additional information do you/your colleagues need from the provider to gain a better understanding of their position on each dimension?

- Do you have the capacity to train or provide guidance to this provider about the needs of your youth?

- Based on your organization's values and priorities, is this a provider you want to consider as a referral partner for sexual and reproductive health services?

- How does this provider compare to others in your community?

- If this provider is the only provider in your community and does not fully meet youths' needs, how can you support and advocate for youth who need to access sexual and reproductive health care from this provider?

Section C. Applying Next Steps

You can use the following strategies and resources to support youth and enhance their ability to access sexual and reproductive health care in your community.

Strategies

- Set up meet-and-greets with the providers in your community.
- Provide youth gift cards, ride shares, or bus/public transit tokens to assist with transportation needs.
- Develop and/or offer training for providers focused on the sexual and reproductive health needs of the youth you serve.
- Conduct follow-up meetings with youth referred to these providers to assess their experiences.
- Connect with an existing coalition or convene a local task force with other community organizations and/or providers to ignite a coordinated care network.
- Educate youth on local/state policies and on their rights as they relate to sexual and reproductive health care in individual or group discussions.

Resources

Intersections in the Work to Ensure Youth in State Custody have Access to Sexual Health Care—Fact sheet on how access to sexual and reproductive health care in juvenile justice settings intersects with other youth identities.

Healthcare Provider Survey Report—Report on providers' experiences providing sexual and reproductive health care to youth in the child welfare system and recommendations to improve access.

Trauma Informed Consequences (TICs) for Youth Experiencing Homelessness—Tip sheet on applying a trauma-informed approach to working with and serving youth who have experiences with homelessness.

Supporting the Sexual and Reproductive Health of Youth in Foster Care After Roe—Overview of the barriers to sexual and reproductive health care for youth in the child welfare system and recommendations to improve access since the overturning of ***Roe v. Wade***.

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Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth-Supporting Professionals

Amanda M. Griffin, Colleen Schlecht, and Emma Pliskin

Introduction

"Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth Supporting Professionals" (the Guide) is a research-informed resource designed for

professionals who work with young people who experience the child welfare or justice systems, homelessness, or disconnection from school and work. It is intended to facilitate a conversation that centers young people's birth control preferences, needs, and priorities. The guidance it offers was informed by research and conversations with young people who have lived expertise and with youth-supporting professionals. By using this resource, youth-supporting professionals can empower all young people to choose the birth control method that is right for them.

Activate: The Collective to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals *aims to bridge the gap between research and practice in support of the Office of Population Affairs' mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating research- based resources for use by professionals who support young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from school and work (i.e., opportunity youth).*

The Guide includes three sections that are meant to be used together:

1. Instructions for Using the Guide
2. Background
3. Conversation Starters and Birth Control Methods Matrix

"A Birth Control Methods Information Booklet" (Information Booklet) provides detailed information about all the birth control methods included in the birth control methods matrix. It also includes a glossary of terms. Professionals can use this resource to learn about birth control methods they are not familiar with and can share the information with young people to empower them to choose the birth control method that is right for them.

Instructions for Using the Guide and the Information Booklet

Familiarize yourself with the questions, statements, and birth control methods matrix in the Conversation Starters and Birth Control Methods Matrix ahead of talking with a young person. For additional guidance, read Activate's "Six Tips for Youth-Supporting Professionals for Talking with Youth about Sexual and Reproductive Health."

1. Review the Background section which summarizes the research informing this Guide.
2. Reflect on the questions at the top of page 4 before starting a conversation about birth control with a young person.

3. Record the young person's responses or have the young person record their responses to the five conversation-starter questions at the bottom of page 4.

4. Read each of the ten statements on page 5 to the young person, or have them read the statements aloud and note which they agree with. Young people may agree with more than one statement.

5. Highlight the columns in the Birth Control Methods Matrix on pages 6 and 7 that correspond to the statements with which the young person agrees. You may need to highlight more than one column.

6. Look for the symbols that appear in all or most of the highlighted columns. These symbols represent the birth methods that best align with the young person's preferences, needs, and priorities. Their preferences, needs, and priorities may align with more than one method of birth control

7. Provide the young person with the page(s) in the Information Booklet that correspond to the birth control methods that best align with their preferences, needs, and priorities.

8. Refer young people who want additional information about their birth control options to online tools such as Bedsider's tool for exploring birth control options. It is designed for women ages 18 to 29 and operated by Power to Decide: The Campaign to Prevent Unplanned Pregnancy.

You should also feel free to use the Guide and Information Booklet in whatever way is most helpful to you and to the young people with whom you work.

Background

Birth control is a personal choice that involves many considerations

Choosing to use birth control (also known as contraception) and choosing which birth control method to use are extremely personal decisions. No birth control method is right for everyone, and what works best for one person may not work best for another.

To make an informed choice about which birth control method to use—or whether to use any method at all—young people need medically accurate information about the full range of birth control options. Moreover, because they are still building decision-making autonomy regarding their sexual and reproductive health, they may also need support in choosing a birth control method.[1] This may be especially important for young people who are involved with the child welfare or justice systems, experiencing homelessness, or disconnected from school and work.

Research on factors that influence birth control choice has focused on young women

Research suggests that young women in the general population who are choosing a birth control method must consider the attributes of different methods, such as side effects, effectiveness, cost, effort involved, and user control; contextual factors, such as reproductive history, relationship characteristics and previous contraceptive experiences, and attitudes toward pregnancy; and factual and experiential information provided by peers, family members, and health care providers.[2,3]

Research on factors that influence birth control choice among young people with certain experiences is limited

Comparatively fewer studies have looked at the factors that are important to young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from work and school when they are choosing what birth control to use. Furthermore, these studies involve small, nonrepresentative samples, so their findings may not generalize to the population of young people who experience the child welfare and/or justice systems, homelessness, and/or disconnection from work and school. Despite their limitations, the studies do point to some of the same factors that influence the contraceptive choices of young women in the general population. These include the experiences of family and friends, the responses of their partners,[3-5] maintenance requirements,[6] side effects,[7,8] insurance coverage,[6] and pregnancy attitudes.[9] Finally, research suggests that these young people want more information about their contraceptive options, including information about side effects and relative effectiveness.[6]

Some populations of young people have been excluded from most research on factors that influence birth control choice

To date, young men have largely been excluded from research on factors that influence young people's choice of birth control methods. Some studies examine the role that partners play in decision making about birth control, but none of these studies included young men as study participants. Two factors probably contribute to the exclusion of young men from this research. First, the birth control options available to young men are far more limited than those available to young women. Second, young women are often the focus of research because they are most directly affected when a birth control method fails and a pregnancy occurs. However, excluding young men from this research reinforces the notion that young men have no role to play in pregnancy prevention and that young women are solely responsible for using birth control.

Many researchers assume that lesbian or gay young people are not at risk for pregnancy, and exclude them from studies as a result.[10,11] There are, however, exceptions: Some studies have found that some people may seek birth control to suppress menstruation, not just for pregnancy prevention.[12,13] Given that lesbian and gay young people are overrepresented among young people involved with the child welfare and/or justice systems, experiencing homelessness, and/or are disconnected from work and school,[14] it is important for youth-supporting professionals to be aware of their needs and preferences.

Conversation Starters and Birth Control Methods Matrix

The Conversation Starters and Birth Control Methods Matrix aim to help professionals facilitate a conversation with young people about choosing the birth control methods best for them. This section of the Guide includes questions to start the conversation; statements to help young people identify their birth control preferences, needs, and priorities; and a birth control methods matrix that professionals can use interactively with young people to guide their decision-making about birth control methods and aid in using the Information Booklet.

Before Starting a Conversation with Young People about Choosing Birth Control

We recommend reflecting on the following five questions before starting a conversation about birth control with a young person:

1. Is your location one in which the young person will feel safe and you can have a private conversation?
2. Will you feel comfortable having a conversation about choosing a birth control method with this young person?
3. Are you prepared to listen to the young person and avoid being judgmental?
4. Have you built enough rapport with the young person to ask sensitive questions?
5. Do you believe you are the best person to have this conversation with the young person?

Questions to Start Conversations about Choosing Birth Control

You can use these questions to begin a conversation about choosing birth control. Questions 1 and 2 ask young people to describe their interests in having children in the future and their current birth control choices. Questions 3 to 7 ask young people to think about their ability to access birth control.

Some questions may be particularly relevant for young people involved with the child welfare and/or justice systems, experiencing homelessness, and/or disconnected from work and school. The birth control choices of these young people may also be affected by factors not reflected in these questions. For example, because young people experiencing homelessness may not have health insurance or a health care provider, they may choose a method that is inexpensive and available over the counter.[15] Likewise, the methods that young people in foster care choose may depend on whether they are living in a foster home, a group care setting, or their own apartment.

1. Do you see yourself having a child (or another child) in the future? If so, when?
2. What, if any, form of birth control are you currently using? Why did you choose that form of birth control?
3. Do you have someone you can count on to help you access birth control?
4. What barriers might make it difficult for you to access birth control?
5. Do you have a health care provider you feel comfortable going to?
6. Do you have transportation to a health care provider?
7. Do you have health insurance?

Using the Birth Control Methods Matrix

You can use the 10 statements below to help young people choose a contraceptive method that is right for them. Each statement focuses on a feature of certain contraceptive methods that may or may not be important to a particular young person. Read each statement with the young person or ask them to read the statement and ask whether they agree or disagree. If the young person agrees with the statement, the table indicates which column(s) they should look at in the contraceptive matrix on page 6 for birth control methods that align with their preferences, needs, and priorities. Young people may agree with more than one statement so they may have to look at more than one column to find the birth control methods with which their preferences, needs, and priorities are best aligned.

	If agree, go to
1. I prefer a method that I can get without going to a health care provider.	☐ Column 1
2. I prefer to have a hormone-free method.	☐ Column 2
3. I would not feel comfortable inserting a birth control device inside my body.	☐ Column 3
4. I would not feel comfortable having a health care provider insert a birth control device inside my body.	☐ Column 4
5. I prefer a method that will be invisible to my partner.	☐ Column 5
6. I prefer a method that will last for more than a year.	☐ Column 6
7. I prefer a method that I only use or think about when I have sex.	☐ Column 7
8. I prefer a method that will permanently prevent pregnancy.	☐ Column 8
9. I prefer a method that also protects against STIs/HIV.	☐ Column 9
10. I need a method for males.	☐ Column 10

Note: These statements are designed help young people identify the birth control methods they might want to consider. However, they do not cover the full range of factors that may be important when it comes to choosing a method of birth control. For example, they do not address the side effects or potential benefits of some birth control methods. That information, along with other details about each method, can be found in the Information Booklet. The information in the booklet can also be shared with young people to help them further narrow down their choice of birth control. Depending on the birth control method they choose, young people may need an appointment with a healthcare provider.

The birth control methods in the matrix are divided into five categories:

Use the Matrix as a starting point to identify possible birth control methods with young people. The Information Booklet provides important and more detailed information about each birth control method that young people select. You can print and share the information about each birth control method to help young people to choose the birth control method that is right for them.

Long-term reversible: These are the most effective reversible methods of birth control, last for several years, and can be removed at any time.

Short-term hormonal: These birth control methods use hormones to prevent pregnancy. They are effective but not as effective as long-term reversible methods.

Short-term barrier: These birth control methods prevent pregnancy by blocking sperm from passing through the cervix. They are less effective than long-term reversible or hormonal methods.

Short-term behavioral: These birth control methods require users to engage in specific behaviors to prevent pregnancy. They are less effective than long-term reversible or hormonal methods.

Permanent: These birth control methods permanently prevent pregnancy and are highly effective.

Birth Control Methods Matrix

Birth Control Methods	Does NOT require going to a health care provider	Hormone-free	Does NOT require YOU to insert a device inside your body yourself	Does NOT require a health care provider to insert a device inside your body	Invisible to your partner	Lasts for more than one year	Need to think about each time you have sex	Permanently prevents pregnancy	Protects against STIs& HIV	For males
	1	2	3	4	5	6	7	8	9	10
Long-term reversible										
LNG IUD—T										
Copper T IUD										
Implant										
Short-term hormonal										
Injection or "shot"										
Oral contraceptives (combined)										
Oral contraceptives (progestin only)										
Transdermal contraceptive patch										
Contraceptive ring										
Emergency contraceptive pill										

Birth Control Methods	Does NOT require going to a health care provider	Hormone-free	Does NOT require YOU to insert a device inside your body yourself	Does NOT require a health care provider to insert a device inside your body	Invisible to your partner	Lasts for more than one year	Need to think about each time you have sex	Permanently prevents pregnancy	Protects against STIs& HIV	For males
	1	2	3	4	5	6	7	8	9	10
Short-term barrier										
Diaphragm / cervical cap										
Sponge										
Spermicide / contraceptive gel										
Internal ("female") condom										
External ("male") condom										
Short-term behavioral										
Fertility awareness-based methods										
Withdrawal										
Permanent										
Tubal ligation or "tying tubes"										
Vasectomy										

*In some states, these birth control methods can either be prescribed by a pharmacist or dispensed by a pharmacist without a prescription. To see if you live in one of these states, go to https://www.guttmacher.org/state-policy/explore/pharmacist-prescribed-contraceptive

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Helping Young People to Choose the Birth Control Method Right for Them

Birth Control Methods Information Booklet

Amanda M. Griffin, Colleen Schlecht, and Emma Pliskin

The goal of Activate: The Collective to Bring Adolescent Sexual and Reproductive Health Research to Youth-Supporting Professionals is to bridge the gap between research and practice to support the Office of Population Affair's mission to prevent unintended teen pregnancy and promote adolescent health. Activate translates research into practice by creating resources for professionals who support young people involved with the child welfare and/or justice system, experiencing homelessness, and/or disconnected from work and school (i.e., opportunity youth).

Table of Contents

Introduction 1

Levonorgestrel intrauterine system (LNG IUD) 2

Copper T intrauterine device (IUD) 3

 Implant 4

Injection or "Shot" 5

Oral Contraceptive Pill (Combined) 6

Oral Contraceptive Pill (Progestin only) 7

Transdermal Contraceptive Patch 8

Contraceptive Ring 9

Emergency Contraceptive Pill: Ella 10

Emergency Contraceptive Pill: Levonorgestrel 11

Diaphragm 12

Cervical Cap 13

Sponge 14

Spermicide/Contraceptive Gel 15

Internal (Female) Condom 16

External (Male) Condom 17

Fertility Awareness-Based Methods 18

Withdrawal 19

Tubal Ligation or "Tying Tubes" 20

Vasectomy 21

Glossary of Key Terms 22

Introduction

Birth control, also known as contraception, is a method or device used to prevent pregnancy. Choosing which birth control method to use is an extremely personal decision. No contraceptive method is the right choice for everyone, and what works best for one person may not work as well for another. To make an informed choice, young people—who may have less experience using birth control and be less aware of their needs and preferences—require medically accurate information about the full range of birth control options. This is no less true for young people who are involved with the child welfare or justice systems, who are experiencing homelessness, and who are disconnected from work and school.

Activate developed this booklet to help youth-supporting professionals empower these young people to choose the birth control method that is right for them. Except where otherwise noted, we drew on information from several online sources, including Bedsider, the Cleveland Clinic, the Centers for Disease Control and Prevention, and the Food and Drug Administration.[1-5] The booklet addresses the following questions about 18 birth control methods:[6]

- What is it?
- What type of method is it?
- What brands are available?
- Who can use it?
- How is it used?
- Can it be reused?
- How long does it last?
- Does it require an appointment with a health care provider?
- Does this method require a prescription?
- Does it prevent STIs?
- Can you get pregnant in the future if you use this method now?
- What percentage of users are likely to get pregnant within the first 12 months with typical use? [7-9]
- What percentage of users are likely to get pregnant within the first 12 months with perfect use?
- What are some side effects of using this method?
- What are the potential benefits of using this method?
- What are the less common risks associated with using this method?
- Who should not use this method?

The booklet also includes some follow-up questions that youth-supporting professionals to ask young people who are considering a particular method of birth control as well as a glossary of key terms. The booklet is designed to be used in conjunction with the *Helping Young People Choose the Birth Control Method Right for Them: A Guide for Youth-Supporting Professionals*, which youth-supporting professionals can use to guide young people's contraceptive decision making.

Levonorgestrel intrauterine system (LNG IUD)

What is it?	Small T-shaped device placed inside the uterus that releases progestin
What type of method is it?	Intrauterine hormonal & Long-acting reversible contraceptive (LARC)
What brands are available?	Mirena, Kyleena, Liletta, & Skyla
Who can use it?	Females
How is it used?	Placed into the uterus by a healthcare provider
Can it be reused?	No
How long does it last?	3-7 years
Does it require an appointment with a health care provider?	Yes—One to place the IUD and one to check its placement
Does this method require a prescription?	Yes---It must be prescribed by a healthcare provider before insertion
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	0.1%-0.4%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.1%-0.3%
What are some of the side effects of using this method?	Spotting between periods, irregular periods, and cramps
What are the potential benefits of using this method?	Reduced cramps, lighter or no periods, and private (i.e., invisible to a partner)
What are the less common risks associated with using this method?	Rarely pushes through the uterine wall during insertion; pelvic inflammatory disease or ectopic pregnancy
Who should not use this method?	Individuals who are pregnant Individuals with any of the following medical conditions should consult a doctor prior to use: anatomical abnormalities; breast, cervical, or endometrial cancer; pelvic inflammatory disease; postpartum sepsis; gestational trophoblastic disease; sexually transmitted infection, tuberculosis, or unexplained vaginal bleeding

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Copper T intrauterine device (IUD)

What is it?	Small T-shaped copper device placed inside the uterus
What type of method is it?	Intrauterine & LARC
What brands are available?	Paragard
Who can use it?	Females
How is it used?	Placed into the uterus by a healthcare provider; can act as emergency contraception if inserted within 5 days of unprotected sexual intercourse
Can it be reused?	No
How long does it last?	4-12 years[10]
Does it require an appointment with a health care provider?	Yes—One to place the IUD and one to check its placement
Does this method require a prescription?	Yes---It must be prescribed by a healthcare provider before insertion
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	0.8%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.6%
What are some of the side effects of using this method?	Spotting between periods, irregular periods, heavy bleeding, anemia, and cramps
What are the potential benefits of using this method?	Non-hormonal, long-lasting, and private (i.e., invisible to a partner)
What are the less common risks associated with using this method?	Rarely pushes through the uterine wall, slips out, or results in an infection
	Individuals who are pregnant Individuals with any of the following medical conditions should consult a doctor prior to use: anatomical abnormalities, endometrial or cervical cancer, pelvic inflammatory disease, are post-abortion, have postpartum sepsis, confirmed gestational trophoblastic disease, have a sexually transmitted disease, tuberculosis, or unexplained vaginal bleeding

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Implant

What is it?	Single, thin rod placed under the skin of the upper arm that releases progestin
What type of method is it?	Hormonal & LARC
What brands are available?	Nexplanon
Who can use it?	Females
How is it used?	Placed under the skin in the upper arm by a healthcare provider
Can it be reused?	No
How long does it last?	FDA approved for 3 years, but shown to be effective for 5 years
Does it require an appointment with a health care provider?	Yes—One to place the implant and one (potentially telehealth) for follow-up
Does this method require a prescription?	Yes---It must be prescribed by a healthcare provider before implantation
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	0.1%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.1%
What are some of the side effects of using this method?	Spotting or irregular periods (especially for the first 6-12 months); less common side effects include acne, change in appetite or sex drive, ovarian cysts, depression, discoloring or scarring on the skin over the implant, dizziness, hair loss, headache, nausea, nervousness, and sore breasts
What are the potential benefits of using this method?	Reduced cramps, lighter or no periods, and private (i.e., invisible to a partner)
What are the less common risks associated with using this method?	Insertion or removal complications
Who should not use this method?	Individuals who have breast cancer

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Injection or "Shot"

What is it?	Shot of progestin in the buttocks or arm
What type of method is it?	Hormonal
What brands are available?	Depo-Provera
Who can use it?	Females
How is it used?	Shot in the buttocks or arm by a healthcare provider
Can it be reused?	No
How long does it last?	3 months
Does it require an appointment with a health care provider?	Yes—Every 3 months
Does this method require a prescription?	Yes—It must be prescribed by a healthcare provider
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	4%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.2%
What are some of the side effects of using this method?	Loss of bone density (after 2 years), irregular bleeding or bleeding between periods, appetite changes, weight gain Less common side effects include changes in sex drive, depression, hair loss, more body or facial hair, nervousness, dizziness, headache, nausea, and sore breasts
What are the potential benefits of using this method?	Lighter periods after 1 year of use, prevention of uterine cancer, and private (i.e., invisible to a partner)
What are the less common risks associated with using this method?	None reported
Who should not use this method?	Individuals who have breast cancer

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Are you afraid of needles?

Oral Contraceptive Pill (Combined)

What is it?	Pill that combines estrogen and progestin
What type of method is it?	Hormonal
What brands are available?	Kariva, Reclipsen, Solia, Yasmin, and Yaz
Who can use it?	Females
How is it used?	Taken by mouth at the same time every day
Can it be reused?	No
How long does it last?	1 day
Does it require an appointment with a health care provider?	Yes—Healthcare providers in some states allow telehealth appointments, and in some states, the health care provider can be a pharmacist
Does this method require a prescription?	Yes—In some states, health care providers will prescribe the combined birth control pill via an app or telehealth appointment Some states allow pharmacists to prescribe the combined birth control pill or to dispense the combined birth control pill to individuals without a prescription[11]
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	7%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.3%
What are some of the side effects of using this method?	Spotting between periods, nausea, breast tenderness, headaches, or change in sex drive; side effects typically lessen or stop after the first 2 to 3 months
What are the potential benefits of using this method?	Lighter and more regular period; reduced cramps or PMS; less or no acne; prevention of bone thinning, breast or ovary cysts, ectopic pregnancy, endometrial and ovarian cancers, and anemia
What are the less common risks associated with using this method?	Rare but serious risks include high blood pressure, blood clots, heart attacks, or strokes
Who should not use this method?	Individuals who are breastfeeding and/or <21 days postpartum (or < 42 days with other risk factors) Individuals with any of the following medical conditions should consult a doctor prior to use: history of stroke, migraine headaches, breast or liver cancer, cirrhosis, deep venous thrombosis, pulmonary embolism, hypertension, heart disease, lupus, solid organ transplant, or peripartum cardiomyopathy

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider or pharmacy?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you be able to take a pill at the same time every day?

Oral Contraceptive Pill (Progestin only)

What is it?	Progestin-only pill
What type of method is it?	Hormonal
What brands are available?	Aygestin, Camila, Errin, Heather, Jencycla, Jolivette, Nora-Be, Ortho-Micronor, Nor-QD, Heather, Jencycla, Norlyroc, Deblitane, Sharobel, Lyza, Norlyda, Tulana, Incassia, Lyleq (Norethindrone), Opill (Norgestrel), Slynd (Drosperidone)
Who can use it?	Females
How is it used?	Taken by mouth at the same time every day
Can it be reused?	No
How long does it last?	1 day
Does it require an appointment with a health care provider?	Yes—Health care providers in some states allow telehealth appointments and, in some states, the health care provider can be a pharmacist
Does this method require a prescription?	Depends—In some states, health care providers will prescribe the progestin-only birth control pill via an app or telehealth appointment; some states allow pharmacists to prescribe the progestin-only birth control pill or to dispense it to individuals without a prescription[12] Opill is available without a prescription from select retailers
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	7% (2% for Opill)
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.3%
What are some side effects of using this method?	Irregular bleeding, acne, breast tenderness, headaches, nausea, change in sex drive, and ovarian cysts; side effects typically lessen or stop after the first 2 to 3 months
What are the potential benefits of using this method?	Lighter periods Slynd has a 24-hour window in which to take a missed pill
What are the less common risks associated with using this method?	None reported
Who should not use this method?	Individuals who have breast cancer

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider or pharmacy?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you be able to take a pill at the same time every day?

Transdermal Contraceptive Patch

What is it?	Patch worn on the lower abdomen, buttocks, or upper body (but not on the breasts) where it releases progestin and estrogen
What type of method is it?	Hormonal
What brands are available?	Xulane and Twirla
Who can use it?	Females
How is it used?	Placed on the skin by the user each week for 3 weeks then not placed in week 4 to have a menstrual period
Can it be reused?	No
How long does it last?	1 week
Does it require an appointment with a health care provider?	Yes—Health care providers in some states allow telehealth appointments and, in some states, the health care provider can be a pharmacist
Does this method require a prescription?	Yes—Some states allow pharmacists to prescribe the patch or to dispense the patch to individuals without a prescription[13]
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	7%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.3%
What are some of the side effects of using this method?	Spotting between periods, nausea, breast tenderness, headache (first 2 to 3 months), skin irritation, and change in sex drive
What are the potential benefits of using this method?	Lighter and more regular period; reduced cramps or PMS; prevention of bone thinning, breast or ovarian cysts, ectopic pregnancy, endometrial and ovarian cancers, and anemia
What are the less common risks associated with using this method?	Rare but serious risks include high blood pressure, blood clots, heart attacks, or strokes
Who should not use this method?	Individuals who are breastfeeding and/or postpartum <21 days postpartum (or < 42 days with other risk factors) Individuals with any of the following medical conditions should consult a doctor prior to use: history of stroke, migraine headaches, breast or liver cancer, cirrhosis, deep venous thrombosis, pulmonary embolism, hypertension, heart disease, lupus, solid organ transplant, or peripartum cardiomyopathy

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider or pharmacy?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Contraceptive Ring

What is it?	Small flexible ring placed inside the vagina where it releases progestin and estrogen
What type of method is it?	Hormonal
What brands are available?	NuvaRing and Annovera
Who can use it?	Females
How is it used?	Placed into the vagina by the user for 3 weeks then taken out for 7 days
Can it be reused?	NuvaRing: No—Insert a new ring after 7 days with no ring Annovera: Yes—Reuse same ring after 7 days with no ring for 13 cycles
How long does it last?	NuvaRing: 3 weeks Annovera: 1 year
Does it require an appointment with a health care provider?	Yes—Health care providers in some states allow telehealth appointments and, in some states, the health care provider can be a pharmacist
Does this method require a prescription?	Yes—Some states allow pharmacists to prescribe the ring or to dispense the ring to individuals without a prescription[14]
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	7%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.3%
What are the side effects of using this method?	Bleeding between periods nausea and vomiting, breast tenderness, vaginal discharge, and discomfort or mild irritation
What are the potential benefits of using this method?	Lighter and more regular period; reduced cramps or premenstrual syndrome (PMS); less or no acne; prevention of bone thinning, breast or ovary cysts, endometrial and ovarian cancers, or anemia
What are the less common risks associated with using this method?	Rare but serious risks include high blood pressure, blood clots, heart attacks, or strokes
Who should not use this method?	Individuals with any of the following medical conditions should consult a doctor prior to use: history of stroke, migraine headaches, breast or liver cancer, cirrhosis, deep venous thrombosis, pulmonary embolism, hypertension, heart disease, lupus, solid organ transplant, or peripartum cardiomyopathy

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider or pharmacy?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you feel comfortable inserting this device inside your body?

Emergency Contraceptive Pill: Ella

What is it?	Pill with ulipristal acetate taken up to 5 days after unprotected sex
What type of method is it?	Hormonal
What brands are available?	Ella
Who can use it?	Females
How is it used?	Taken by mouth as soon as possible after having unprotected sexual intercourse; must wait 5 days before (re)starting a different hormonal contraceptive method
Can it be reused?	No
How long does it last?	Can work up to 5 days after unprotected sexual intercourse
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	Yes
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	89% effective at preventing a pregnancy if taken within 72 hours
What % of users are likely to get pregnant within the first 12 months with perfect use?	N/A
What are some of the side effects of using this method?	Bleeding between periods, abdominal pain, breast pain, dizziness, fatigue, headache, nausea; if you experience side effects with EC, they'll probably go away after 24 hours
What are the potential benefits of using this method?	N/A
What are the less common risks associated with using this method?	There is a decreased risk of effectiveness with obesity
Who should not use this method?	Individuals who are pregnant or who used the Levonorgestrel emergency contraceptive pill within the past 5 days

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?
- Do you have transportation to a pharmacy?
- What birth control methods would you consider using on a routine basis?

Emergency Contraceptive Pill: Levonorgestrel

What is it?	Pill with levonorgestrel taken within 72 hours after unprotected sexual intercourse
What type of method is it?	Hormonal
What brands are available?	Plan B One Step, Take Action, My Way, Option 2, Preventeza, AfterPill, My Choice, Aftera, EContra, and Levonelle
Who can use it?	Females
How is it used?	Taken by mouth as soon as possible after having unprotected sexual intercourse; should only be used in emergency situations
Can it be reused?	No
How long does it last?	FDA approved for up to 72 hours after unprotected sexual intercourse; shown to be effective up to 5 days after unprotected sexual intercourse, but effectiveness decreases over time[15]
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	89% effective at preventing a pregnancy if taken within 72 hours
What % of users are likely to get pregnant within the first 12 months with perfect use?	N/A
What are some of the side effects of using this method?	Headaches, nausea, abdominal pain, menstrual pain, irregular bleeding, tiredness, and dizziness
What are the potential benefits of using this method?	N/A
What are the less common risks associated with using this method?	Decreasing effectiveness with obesity
Who should not use this method?	Individuals who are pregnant or who used the Ella "morning after" pill within the past 5 days

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?
- Do you have transportation to a pharmacy?
- What birth control methods would you consider using on a routine basis?

Diaphragm

What is it?	Shallow cup placed inside the vagina to cover the cervix to block sperm; two types: fitted and "one size fits most"
What type of method is it?	Barrier
What brands are available?	Caya® and Milex
Who can use it?	Females
How is it used?	Placed into the vagina with spermicide by the user prior to having sexual intercourse and removed within 24 hours
Can it be reused?	Yes
How long does it last?	Event-specific method, works when in place (when one is having sex)
Does it require an appointment with a health care provider?	Yes, one appointment to be fitted
Does this method require a prescription?	Yes
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	17%
What % of users are likely to get pregnant within the first 12 months with perfect use?	16%
What are some of the side effects of using this method?	Vaginal irritation and frequent urinary tract infections
What are the potential benefits of using this method?	Non-hormonal; reduced risk of pelvic inflammatory disease and tubal infertility
What are the less common risks associated with using this method?	Toxic shock syndrome if not removed after 24 hours
Who should not use this method?	Individuals who are at high risk for HIV/AIDS or who gave birth/had a second-trimester abortion less than 6 weeks ago

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you feel comfortable inserting this device inside your body?
- Are you confident you will be able to use this birth control method each time you have sex?

Cervical Cap

What is it?	Thimble-shaped cup placed inside the vagina to block sperm by covering the cervix
What type of method is it?	Barrier
What brands are available?	FemCap
Who can use it?	Females
How is it used?	Placed into the vagina with spermicide by the user prior to having sexual intercourse and removed within 24 hours
Can it be reused?	Yes
How long does it last?	Event-specific method, works when in place (when one is having sexual intercourse)
Does it require an appointment with a health care provider?	Yes—One appointment to be fitted
Does this method require a prescription?	Yes
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	If no prior childbirth: 14% If prior childbirth: 29%
What % of users are likely to get pregnant within the first 12 months with perfect use?	Not reported
What are some of the side effects of using this method?	Vaginal irritation and frequent urinary tract infections
What are the potential benefits of using this method?	Non-hormonal; reduced risk of pelvic inflammatory disease and tubal infertility
What are the less common risks associated with using this method?	Toxic shock syndrome if not removed after 48 hours
Who should not use this method?	Individuals who gave birth/had a second-trimester abortion less than 6 weeks ago Individuals who have silicone or spermicide allergies or are at high risk for HIV/AIDS

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you feel comfortable inserting this device inside your body?
- Are you confident you will be able to use this birth control method each time you have sex?

Sponge

What is it?	Spermicide-containing sponge that is placed in the vagina where it fits over the cervix
What type of method is it?	Barrier
What brands are available?	Today Sponge
Who can use it?	Females
How is it used?	Placed into the vagina by the user no more than 18 hours prior to having sexual intercourse and kept in for at least 6 hours after
Can it be reused?	No
How long does it last?	Up to 24 hours
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	If no prior childbirth: 14% If prior childbirth: 27%
What % of users are likely to get pregnant within the first 12 months with perfect use?	If no prior childbirth: 9% If prior childbirth: 20%
What are some of the side effects of using this method?	Irritation
What are the potential benefits of using this method?	Non-hormonal and can be placed up to 24 hours prior to intercourse
What are the less common risks associated with using this method?	Toxic shock syndrome if not removed after 24 hours
Who should not use this method?	Individuals who recently gave birth Individuals who have silicone, sulfite, or polyurethane allergies; HIV/AIDS; a vaginal infection; or a history of toxic shock syndrome

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?
- Would you feel comfortable inserting this device inside your body?
- Are you confident you will be able to use this birth control method each time you have sex?
- Do you have transportation to a pharmacy?

Spermicide/Contraceptive Gel

What is it?	Foam, gel, cream, film, suppository, or tablet that kills sperm
What type of method is it?	Barrier
What brands are available?	Advantage-S, Conceptrol, Crinone, Delfen Foam, Phexxi
Who can use it?	Females
How is it used?	Placed into the vagina by the user no more than 1 hour prior to having sexual intercourse and kept in for at least 6-8 hours after; used with diaphragm or cervical cap.
Can it be reused?	No
How long does it last?	7-9 hours
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No—Except Phexxi, which requires a prescription via telehealth
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	21%
What % of users are likely to get pregnant within the first 12 months with perfect use?	16%
What are some of the side effects of using this method?	Irritation
What are the potential benefits of using this method?	Non-hormonal
What are the less common risks associated with using this method?	Urinary tract infections and, if used frequently, an increased risk for HIV.
Who should not use this method?	Individuals at high risk for HIV

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?
- Are you confident you will be able to use this birth control method each time you have sex?
- Do you have transportation to a pharmacy?
- Would you feel comfortable inserting this substance inside your body?

Internal (Female) Condom

What is it?	Little nitrile (soft plastic) pouches placed into vagina to prevent sperm from entering the vagina
What type of method is it?	Barrier
What brands are available?	Cupid's Female Condoms and FC2 Female Condoms
Who can use it?	Females
How is it used?	Placed into the vagina up to 8 hours before having sexual intercourse; can also be inserted into the anus to prevent STIs during anal intercourse; cannot be used with male condom
Can it be reused?	No
How long does it last?	Event-specific method, works when in place (when one is having sex)
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	Yes
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	21%
What % of users are likely to get pregnant within the first 12 months with perfect use?	5%
What are some of the side effects of using this method?	Irritation
What are the potential benefits of using this method?	Non-hormonal and protects against STIs
What are the less common risks associated with using this method?	Urinary tract infection
Who should not use this method?	Individuals with latex allergies should avoid latex condoms Individual with sensitivity to spermicide should use a condom without spermicide

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Are you confident you will be able to use this birth control method each time you have sex?
- Do you have transportation to a pharmacy?
- Would you feel comfortable inserting this device inside your body?

External (Male) Condom

What is it?	Thin, stretchy pouch that is worn over the penis to prevent sperm from entering the vagina
What type of method is it?	Barrier
What brands are available?	Durex and Trojan
Who can use it?	Males
How is it used?	Placed on the penis prior to having sexual intercourse; cannot be used with female condom
Can it be reused?	No
How long does it last?	Event-specific method, works when in place (when one is having sexual intercourse)
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	Yes
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	13%
What % of users are likely to get pregnant within the first 12 months with perfect use?	2%
What are some of the side effects of using this method?	Irritation
What are the potential benefits of using this method?	Non-hormonal and protects again STIs
What are the less common risks associated with using this method?	Urinary tract infection
Who should not use this method?	Individuals with latex allergies should avoid latex condoms Individual with sensitivity to spermicide should use a condom without spermicide

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Are you confident you will be able to use this birth control method each time you have sex?
- Do you have transportation to a pharmacy?

Fertility Awareness-Based Methods

What is it?	Using the body basal temperature and cervical mucus method to determine whether you are at a point in your menstrual cycle at which you are likely to become pregnant; requires a lot of time, planning, and willpower to use
What type of method is it?	Behavioral
What brands are available?	N/A
Who can use it?	Females
How is it used?	Tracked daily
Can it be reused?	N/A
How long does it last?	N/A
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	2%-23% depending on the specific method used
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.4%-5%
What are some of the side effects of using this method?	N/A
What are the potential benefits of using this method?	Non-hormonal
What are the less common risks associated with using this method?	N/A
Who should not use this method?	Individuals less than 4 weeks postpartum or less than 6 weeks postpartum if breastfeeding Individuals who have irregular vaginal bleeding or discharge or acute diseases that elevate body temperature; who use drugs that affect cycle regularity, hormones, or fertility signs; or who are not willing/able to abstain from sexual intercourse during fertile periods

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?

Withdrawal

What is it?	Relying on pulling the penis out of the vagina before ejaculation to avoid pregnancy; also called the "pull-out method"; requires a lot of willpower to use
What type of method is it?	Behavioral
What brands are available?	N/A
Who can use it?	Males
How is it used?	Pulling the penis out of the vagina before ejaculation to avoid pregnancy
Can it be reused?	N/A
How long does it last?	Event-specific method when one is having sex
Does it require an appointment with a health care provider?	No
Does this method require a prescription?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	Yes
What % of users are likely to get pregnant within the first 12 months with typical use?	22%
What % of users are likely to get pregnant within the first 12 months with perfect use?	4%
What are the most common side effects of using this method?	N/A
What are the potential benefits of using this method?	Non-hormonal
What are the less common risks associated with using this method?	N/A
Who should not use this method?	Individuals not willing/able to withdraw

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Would you be willing to use this method in combination with a condom to prevent STIs?

Tubal Ligation or "Tying Tubes"

What is it?	Surgically closing the fallopian tubes so sperm and eggs cannot meet for fertilization
What type of method is it?	Surgical
What brands are available?	N/A
Who can use it?	Females
How is it used?	Surgical
Can it be reused?	N/A
How long does it last?	Forever
Does it require an appointment with a health care provider?	Yes
Does this method require a prescription?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	No
What % of users are likely to get pregnant within the first 12 months with typical use?	0.5%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.5%
What are some of the side effects of using this method?	N/A
What are the potential benefits of using this method?	Non-hormonal and only needs to be done once
What are the less common risks associated with using this method?	Possible complications with surgery, like bleeding, infection, or a reaction to anesthesia. Very rarely, the tubes may reconnect themselves—which could lead to a pregnancy.
Who should not use this method?	Individuals considering having children in the future

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Vasectomy

What is it?	Surgically sealing the vas deferens to prevent sperm from entering the penis
What type of method is it?	Surgical
What brands are available?	N/A
Who can use it?	Males
How is it used?	Surgical
Can it be reused?	N/A
How long does it last?	Forever
Does it require an appointment with a health care provider?	Yes
Does this method require a prescription ?	No
Does it prevent STIs?	No
Can you get pregnant in the future if you use this method now?	No
What % of users are likely to get pregnant within the first 12 months with typical use?	0.15%
What % of users are likely to get pregnant within the first 12 months with perfect use?	0.1%
What are common of the side effects of using this method?	N/A
What are the potential benefits of using this method?	Non-hormonal and only needs to be done once
What are the less common risks associated with using this method?	Possible complications with surgery, like bleeding, infection, or a reaction to anesthesia
Who should not use this method?	Individuals considering having children in the future

What are some follow-up questions for youth-supporting professionals to ask young people who might be considering this birth control method?

- Do you have a health care provider you feel comfortable going to?
- Do you have transportation to a health care provider?
- Do you have health insurance?
- Would you be willing to use this method in combination with a condom to prevent STIs?

Glossary of Key Terms[16]

This glossary of terms may help you understand the information contained in this booklet. It can also be used to explain the information in this booklet to young individuals.

Barrier birth control methods prevent pregnancy by blocking sperm from passing through the cervix. Examples include condoms, diaphragms, foam, sponges, and cervical caps.

Basal body temperature method is a fertility awareness-based birth control method that involves tracking body temperature over time to predict ovulation.

Birth control is any behavior, device, medicine, or procedure used to prevent pregnancy—also known as contraception.

Cervical mucus monitoring is one fertility awareness-based birth control method that involves tracking changes in the appearance and quantity of cervical mucus.

Cervix is the narrow, lower part of the uterus, with a small opening that connects the uterus to the vagina.

Contraception is any behavior, device, medicine, or procedure used to prevent pregnancy—also known as birth control.

Ectopic pregnancy is a pregnancy in which the fertilized egg implants outside the uterus.

Eggs are reproductive cells stored in the ovaries and released during ovulation. Pregnancy happens when sperm enters an egg, grows into a ball of cells, and implants into the uterus.

Ejaculation is the moment at which semen spurts out of the opening of the urethra in the glans of the penis.

Estrogen is a hormone made in the ovaries that plays a part in puberty, the menstrual cycle, and pregnancy.

Fallopian tubes are narrow tubes that carry an egg from the ovary to the uterus during ovulation.

Fertilization is the joining of an egg and a sperm.

Hormonal birth control uses hormones to prevent pregnancy. Examples include the implant, the hormonal IUD, the pill, the patch, the ring, and the shot.

Intrauterine refers to a device placed inside the uterus.

Long-acting reversible contraceptives (LARCs), which include IUDs and implants, are the most effective methods of birth control, last for several years, and can be removed at any time.

Menstrual cycle is the time from the first day of one period to the first day of the next period. During the menstrual cycle, the lining of the uterus grows, an egg is released by the ovaries, and the uterine lining sheds.

Menstrual period is the monthly flow of blood and tissue from the uterus and out of the vagina if a pregnancy doesn't occur.

Penis is a reproductive and sex organ made of spongy tissue that fills with blood during sexual excitement (known as erection).

Perfect use is the effectiveness of a birth control method if always used exactly the right way.

Premenstrual syndrome (PMS) is a combination of symptoms that many women get about a week or two before their menstrual period.

Progestin is a synthetic version of the hormone progesterone found in all hormonal birth control methods.

Sexual intercourse is sex that involves penetration of the vagina or anus with a penis.

Sexually transmitted infection (STIs) are passed from one person to another during vaginal, anal, or oral sex, or via sexual skin-to-skin contact.

Sperm are reproductive cells made in the testes that combine with an egg to cause a pregnancy.

Spermicide is chemical birth control found in sponges, foams, creams, films, suppositories, and gels that immobilizes sperm to prevent pregnancy.

Typical use is the effectiveness of a particular birth control method when accounting for the fact that individuals don't always use their method consistently or correctly.

Unprotected sex is oral, vaginal, or anal sex without condoms or birth control. It can increase one's chances of getting an STI and/or experiencing an unintended pregnancy.

Uterus is the pear-shaped reproductive organ from which individuals menstruate and where a pregnancy develops—also called "womb."

Vas deferens is a long, narrow, sperm-carrying tube that is cut for a vasectomy.

Vagina is the stretchy passage that connects the vulva with the cervix and uterus.

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Endnotes

[1] www.bedsider.org/birth-control

[2] www.plannedparenthood.org/learn/birth-control

[3] https://my.clevelandclinic.org/health

[4] www.fda.gov/consumers/free-publications-women/birth-control#EC

[5] https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec

[6] Information on the 18 available birth control methods is up-to-date as of August 2022.

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[11] To see if you live in one of these states, go to https://www.guttmacher.org/state-policy/explore/pharmacist-prescribed-contraceptives

[12] To see if you live in one of these states, go to https://www.guttmacher.org/state-policy/explore/pharmacist-prescribed-contraceptives

[13] To see if you live in one of these states, go to https://www.guttmacher.org/state-policy/explore/pharmacist-prescribed-contraceptives

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