Preventing Pregnancy and Promoting Sexual Health among Youth in Care: Results from the Evaluation of a Training for Caregivers and Child Welfare Workers

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Background and Introduction

In April 2009, the National Campaign to Prevent Teen and Unplanned Pregnancy (henceforth, "the National Campaign") convened a roundtable of representatives from eight states, including Illinois, with expertise in child welfare and teenage pregnancy prevention.[1] The purpose of the roundtable was for states to share ideas about preventing pregnancy among youth in foster care and to develop strategic plans for reducing the number of youth in foster care who become pregnant.

As part of its strategic plan, the Illinois Department of Children and Family Services (DCFS) formed a pregnancy prevention workgroup. The workgroup, which began meeting in August 2009, included DCFS administrative staff as well as representatives from Planned Parenthood of Illinois, Illinois Caucus for Adolescent Health, CASA of Cook County, Jane Addams Juvenile Court Foundation, Chapin Hall at the University of Chicago, Uhlich Children's Advantage Network (UCAN), Cook County Court Child Protection Division, and the Illinois Department of Public Health. Recognizing that reducing teen pregnancy among youth in foster care would require a comprehensive approach, the workgroup formed three subcommittees (Curricula and Promising Practices; Policies and Procedures; Innovative Strategies). Each of the subcommittees was tasked with developing a set of policy and practice recommendations.

Based on its review of the literature and discussions with several experts in the field, the Curricula and Promising Practices subcommittee made several recommendations for a comprehensive pregnancy prevention strategy. Two of these recommendations were training related. First, the subcommittee recommended that the Department create and implement a training aimed at helping foster parents and other caregivers talk with youth in care not only about pregnancy prevention but also about sexual health more broadly. The Parent Resources for Information, Development, and Education (PRIDE) curriculum developed by the DCFS, in collaboration with Governors State University and the Child Welfare League of America,

[1] The other seven states were Arizona, Colorado, Massachusetts, Maryland, Michigan, Oklahoma, and Virginia.

and used by DCFS to train foster parent includes a module on developmental issues related to sexuality.[2] This module provides information about healthy child sexual development, identifies indicators of problematic sexual behavior, and outlines techniques for sexuality education. However, it does not cover pregnancy (or HIV and other STI) prevention. In fact, an extensive review of the literature failed to uncover any curriculum that could be used to provide this type of training to foster parents or other caregivers.

Second, the subcommittee recommended the creation and implementation of a similar training for both DCFS and private agency child welfare workers. The Department had established policies and procedures related to the provision of sexual and reproductive health care. However, child welfare workers were not trained to talk with youth in care about pregnancy (or HIV and other STI) prevention. Nor had the sub-committee been able to find an existing curriculum that the Department could use to provide child welfare workers with this type of training.

The subcommittee found support for its training recommendations in data collected by Connect to Protect (C2P), a collaboration among DCFS, Health Works, and the Illinois Caucus for Adolescent Health, that aims to reduce the high risk of HIV/AIDS among youth in care.[3] C2P surveyed 64 foster parents and 94 child welfare workers in the central region of Cook County in August 2009. Eighty-nine percent of the foster parents and 71 percent of the child welfare workers reported wanting more information about how to talk about sex with foster youth. When C2P developed *Communicating with Youth about Sexual Health and HIV Education and Prevention,* a curriculum for foster parents and child welfare workers, and piloted the curriculum in the central region of Cook County, the feedback it received was overwhelmingly positive. Ninety-five percent of the 14 foster parents and 94 percent of the 77 child welfare workers who participated in the training reported that they would feel more comfortable talking to youth about sexual health. In addition, 63 percent of both groups requested additional training on healthy relationships, sexual orientation, and teen dating violence as well as the prevention of pregnancy and STIs.

In response to the subcommittee's recommendations, the Department submitted a proposal to the Illinois Department of Human Services (DHS) to support the development and implementation of a pregnancy prevention and sexual health training for foster parents, other caregivers and child welfare workers. DHS agreed to provide the necessary funding through an interagency agreement, and Chapin Hall at the University of Chicago was asked to evaluate the training. This report presents the results of that evaluation.

The report begins with a description of the curriculum and training and an overview of the study design and methods. It then presents quantitative data collected from the caregivers and child welfare workers who

[2] Currently, the Department requires prospective foster and adoptive parents to complete 27 hours of pre-service PRIDE training.
[3] The Chicago C2P collaborative is part of a 14-city initiative to reduce the rate of HIV/AIDS among adolescents.

completed the training. These data include information about the characteristics of the caregivers and child welfare workers who completed the surveys, their sexual health-related knowledge and attitudes, their experiences talking with youth in care about sexual health, and their perceptions of the training and the trainers. In most cases, data are presented for the entire sample and then separately for caregivers and child welfare workers. (Appendix A presents the data separately by DCFS region.) This is followed by additional information about the training gathered through qualitative interviews with caregivers, child welfare workers, and trainers. The report concludes with a summary of the major findings and a discussion of their implications.

The Curriculum and Training

The pregnancy prevention and sexual health curriculum was developed by the DCFS Division of Support Services' Office of Training and Professional Development in collaboration with the DCFS Division of Service Intervention's Office of Education and Transition Services. It was largely based on two curricula which had been developed by UCAN's Pregnancy Prevention Taskforce to help foster parents and child welfare workers understand and address issues related to sex and sexuality faced by youth in care.[4]

The curriculum was designed to achieve several objectives:

- Educate foster parents and child welfare professionals about healthy sexual development, particularly as it pertains to youth in care who have been exposed to trauma and to those who identify as lesbian, gay, bisexual, or transgender.
- Enhance the ability of foster parents and child welfare professionals to communicate with youth in care about sexual health and engage those youth in discussions about sexuality and sexual behavior.
- Empower foster parents and child welfare professionals to help youth in care make healthy choices about sexual relationships, delay pregnancy, and prevent sexually transmitted infections (STIs).

DCFS piloted the training in Cook County and one downstate region in February 2013. The curriculum was revised based on feedback received during the pilot phase, and the training was rolled out statewide in April 2013.

The curriculum is typically delivered over the course of two days, with each training session lasting three hours. Sessions are highly interactive. Participants engage in games, role plays, and other activities. A variety of supplemental materials (i.e., handouts, videos) are also used. The training is always led by a pair of trainers. Whenever possible, one member of the pair is a DCFS staff trainer while the other is a PRIDE

[4]Since 1998, UCAN has overseen the Teen Parenting Service Network (TPSN) which provides case management and placement services to pregnant and parenting youth in DCFS care.

trainer.[5] A unique feature of the training is that caregivers and child welfare workers attend the same sessions. This was done to encourage caregivers and child welfare workers to work together as a team to promote the sexual health of youth in care.

Caregivers and child welfare workers could obtain information about and register for the training through the Department's Virtual Training Center (VTC) which is maintained by the Office of Training and Professional Development. Those who completed the training received credits that could be applied towards foster parent and professional licensure requirements.[6]

[5] PRIDE trainers are responsible for training foster and adoptive parents.

[6] Foster parents are required to complete at least 16 hours of in-service training as a condition of license renewal.

Study Design and Methods

The evaluation included three major components: pretraining and posttraining surveys, interviews with caregivers and child welfare workers, and interviews with trainers. Each of these components is briefly described below.

Pre- and Posttraining Survey

All caregivers and child welfare workers who participated in the training were asked, but not required, to complete a pretraining survey at the beginning of the first day of the training and a posttraining survey at the end of the second day of the training. Both surveys included questions designed to measure (1) what participants knew about healthy sexual development, (2) whether they perceived a need to talk with youth in care about sexual behavior and health, and (3) how comfortable they would feel talking about sexual behavior and health with youth in care. The posttraining survey also asked caregivers and child welfare workers to rate the training and the trainers. The surveys were administered by the trainers and completed forms were mailed to Chapin Hall.

Survey data were collected over a nine-month period in 2013, beginning in April and ending in December. A total of 44 trainings were held during those nine months. Although the trainers were supposed to administer the surveys on both first and second day of every training session they led, we only received completed surveys from 29 day one and 30 day two sessions. We know that surveys were sometimes not completed because the forms had not been included in the box containing the training materials. In other cases, it is possible that all the caregivers and child welfare workers who had attended the training declined to participate.

To encourage participation in the evaluation, we did not ask caregivers or child welfare workers to write their names on the survey forms or collect any other personally identifying information. The downside to this approach is that it precluded linking responses on the pretraining survey to responses on the posttraining survey, and hence, examining change over time at an individual level.

As a "next best" alternative, we limited our analysis to the 28 trainings from which we received both pretraining and posttraining surveys. We know that the number of caregivers and child welfare workers who completed pretraining survey was usually the same or nearly the same as the number who completed the posttraining survey. We also know from attendance figures we received from the Office of Training and Professional Development that almost all of the caregivers and child welfare workers who attended the trainings completed the surveys. Consequently, if our analysis is limited to the 28 trainings from which we received both pretraining and posttraining surveys, there is a substantial amount of overlap between the pretraining and posttraining samples.

Caregiver and Child Welfare Worker Interviews

At the end of the second day of the training, caregivers and child welfare workers were asked to fill out a "consent to contact" form and indicate if they were willing to be contacted by a member of the Chapin Hall research team about being interviewed by phone. The purpose of the semistructured interviews was to obtain information from caregivers and child welfare workers about their experiences with the training that the survey data would not capture. Caregivers and child welfare workers were also asked to describe how they were applying what they had learned and to share any recommendations for ways the training could be improved.

We had initially planned to contact a random sample of the caregivers and child welfare workers from each of the three DCFS regions (Northern/Cook, Central, and Southern) who gave consent. However, only 58 filled out a "consent to contact" form. Scheduling interviews, particularly with caregivers, proved more challenging than expected. In the end, we were only able to conduct 3 interviews with caregivers and 6 with child welfare workers. All 3 caregivers were foster parents. One was from the Northern/Cook region or Cook County and 2 were from the Southern region. Two of the child welfare workers were from the Northern region or Cook County, 3 were from the Central region, and 1 was from the Southern region.

Trainer Interviews

Chapin Hall was provided with the names and e-mail addresses of the seven DCFS staff trainers and the 27 PRIDE trainers who facilitated trainings. An initial random sample of 3 DCFS staff and 6 PRIDE trainers representing each of the three DCFS regions (i.e., Northern/Cook, Central, or Southern) was selected to be interviewed by telephone. We randomly selected additional trainers into the sample after a number of the e-mail addresses proved to be invalid and several trainers failed to respond. Altogether, an attempt was made to contact 21 trainers but only 5 responded and agreed to be interviewed. One was a DCFS staff trainer and 4 were PRIDE trainers. One trainer was from the Northern region or Cook County, 3 were from the Central region and 1 was a statewide trainer. During the semistructured interview, trainers were asked about their experiences delivering the curriculum, any barriers they encountered, and any strategies they used to increase engagement.

Caregiver and Child Welfare Worker Characteristics

Table 1 shows the characteristics of the 228 caregivers and child welfare workers who completed the pre-training survey. Fifty-two percent of the participants identified themselves as caregivers, 43 percent identified themselves as child welfare workers and 5 percent identified themselves as both. Almost all the caregivers were foster parents, but some were adoptive parents as well. A majority of the child welfare workers were from private (i.e., POS) agencies.[7] A little over half of the training participants were from the Northern region or Cook County, a third was from the Central region and the other 15 percent were from the Southern region. More than three quarters of the caregivers and child welfare workers who completed the pre-training survey are female. More than half described themselves as White and a third described themselves as African American. The mean age of participants was 45 years old, and 58 percent had at least a 4-year college degree.

[7] Purchase of Services (POS) agencies are private child welfare agencies with which the Department has a contract to purchase services.

Table 1. Characteristics of Pretraining Survey Respondents (*N* = 228)

Characteristic	#	%
Relationship to DCFS		
Caregiver only [a]	119	52.2
Child welfare worker only [b]	97	42.5
Both	12	5.3
Region		
Central	74	32.5
Northern/Cook	120	52.6
Southern	34	14.9
Gender		
Female	177	77.6
Male	49	21.5
Missing data	2	0.9
Race		
White	128	56.1
Black	77	33.8
Hispanic	9	4.0
Other	1	0.8
Multiracial	9	4.0
Missing data	3	1.3
Age		
Under 30 years old	23	10.1
30 to 39 years old	54	23.7
40 to 49 years old	49	21.5
50 to 59 years old	53	23.3
At least 60 years	35	15.4
Missing data	14	6.1
Education		
No high school diploma or GED	13	5.7
High school diploma or GED	47	20.6
2-year college degree	33	14.5
4-year college degree	67	29.4
Advanced degree	65	28.5
Missing data	3	1.3

[a] Includes 115 foster parents, 6 relative caregivers and 34 adoptive parents.
[b] Includes 38 DCFS caseworkers, 52 private agency (POS) caseworkers and 9 others.

Table 2 compares the characteristics of the 119 caregivers and the 97 child welfare workers who completed the pretraining survey. A majority of the caregivers were from the Northern region or Cook County; nearly a quarter were from the Southern region. By contrast, the child welfare workers were about evenly split between the Northern region or Cook County and the Central region; only five percent were from the Southern region. Although both caregivers and child welfare workers were predominantly female, they differed with respect to race/ethnicity, age, and education. The caregivers were about evenly split between those who described themselves as white and those who described themselves as African American. However, over 70 percent of the child welfare workers described themselves as white. On average, caregivers were 13 years older than child welfare workers. Caregivers also tended to have less formal

education. Only 22 percent had a least a four year degree compared with 100 percent of the child welfare workers.

Table 2. Characteristics of Pretraining Survey Respondents by Relationship to DCFS

Characteristic	Caregivers (*n* = 119)	Child Welfare Workers (*n* = 97)	Both (*n* = 12)
	%	%	%
Region			
Central	17.7	48.5	50.0
Northern/Cook	58.8	46.4	41.7
Southern	23.5	5.2	8.3
Gender			
Female	70.6	87.6	66.7
Male	27.7	12.4	33.3
Missing data	1.7	0.0	0.0
Race			
White	43.7	71.1	58.3
Black	46.2	17.5	41.7
Hispanic	3.4	5.2	0.0
Other	1.6	0.0	0.0
Multiracial	3.4	5.2	0.0
Missing data	1.7	1.0	0.0
Age			
Under 30 years old	2.5	20.6	0.0
30 to 39 years old	13.5	36.1	25.0
40 to 49 years old	21.9	20.6	25.0
50 to 59 years old	30.3	15.5	16.7
At least 60 years	24.4	2.1	33.3
Missing data	7.6	5.2	0.0
Education			
No high school diploma or GED	10.9	0.0	0.0
High school diploma or GED	38.7	0.0	8.3
2 year college degree	26.1	0.0	16.7
4 year college degree	11.8	49.5	41.7
Advanced degree	10.1	50.5	33.3
Missing data	2.5	0.0	0.0

Table 3 provides additional information about the 131 caregivers who completed the pretraining survey.[8] The number of foster or adoptive children in their care ranged from 0 to 6 with an average of 2, although that number ranged from a low of 0 to a high of 6. Twenty percent were caring for at least one child 0 to 3 years old while 27 percent were caring for at least one child age 16 or older. Two-thirds had been foster or adoptive parents (or both) for more than five years.

[8] Includes caregivers only as well as individuals who were both caregivers and child welfare workers.

Table 3. Caregiver Characteristics (*N* = 131)

Characteristic	#	%
Number of foster/adopted children in care		
0	25	19.1
1	22	16.8
2	21	16.0
3	25	19.1
4	2	1.5
5	12	9.2
6	1	0.8
Missing data	23	17.6
Mean	2.0	
Any child age 0 to 3 years old		
Yes	26	19.9
No	90	68.7
Missing data	15	11.5
Any child age 4 to 7 years old		
Yes	29	22.1
No	87	66.4
Missing data	15	11.5
Any child age 8 to 11 years old		
Yes	36	27.5
No	80	61.1
Missing data	15	11.5
Any child age 12 to 15 years old		
Yes	32	24.4
No	84	64.1
Missing data	15	11.5
Any child age 16 to 21 years old		
Yes	35	26.7
No	81	61.8
Missing data	15	11.5
Years foster/adoptive parent		
No more than 2 years	24	18.3
3 to 5 years	20	15.3
6 to 10 years	21	16.0
11 to 15 years	14	10.7
More than 15 years	36	27.5
Missing data	16	12.2

Table 4 provides additional information about the caregivers who completed the pretraining survey, broken down by DCFS region. On average, caregivers from the Southern region had the fewest foster or adopted children currently in their care. Caregivers from the Central region were the most likely to have been foster or adoptive parents for 15 years or more and the least likely to have been foster or adoptive parents for 5 years or less.

Table 4. Caregiver Characteristics by DCFS Region

Characteristic	Central (*n* = 27)	Northern/Cook (*n* = 75)	Southern (*n* = 29)
	%	%	%
Number of foster or adopted children			
0	25.9	17.3	17.2
1	14.8	13.3	27.6
2	11.1	16.0	20.7
3	7.4	25.3	13.8
4	3.7	1.3	0.0
5	14.8	6.7	10.3
6	3.7	0.0	0.0
Missing data	18.5	20.0	10.3
Any child age 0 to 3 years old			
Yes	18.5	20.0	20.7
No	66.7	69.3	69.0
Missing data	14.8	10.7	10.3
Any child age 4 to 7 years old			
Yes	25.9	17.3	31.0
No	59.3	72.0	58.6
Missing data	14.8	10.7	10.3
Any child age 8 to 11 years old			
Yes	40.7	25.3	20.7
No	44.4	64.0	69.0
Missing data	14.8	10.7	10.3
Any child age 12 to 15 years old			
Yes	14.8	30.7	17.2
No	70.4	58.7	72.4
Missing data	14.8	10.7	10.3
Any child age 16 to 21 years old			
Yes	18.5	30.7	24.1
No	66.7	58.7	65.5
Missing data	14.8	10.7	10.3
Years foster or adoptive parent			
No more than 2 years	7.4	18.7	27.6
3 to 5 years	7.4	17.3	17.2
6 to 10 years	22.2	16.0	10.3
11 to 15 years	7.4	9.3	17.2
More than 15 years	40.7	22.7	27.6
Missing data	14.8	16.0	0.0

Table 5 provides additional information about the 109 child welfare workers who completed the pre-training survey.[9] More than 60 percent had been in the profession for 6 years or more. Almost three-quarters reported that their agency allows them to talk with youth in care about birth control but a quarter did not respond to the survey question their agency's policy.

[9] Includes child welfare workers only as well as individuals who were both child welfare workers and caregivers.

Table 5. Child Welfare Worker Characteristics (*N* = 109)

Characteristic	*n*	%
Years child welfare worker		
No more than 2 years	13	11.9
3 to 5 years	13	11.9
6 to 10 years	34	31.2
11 to 15 years	9	8.3
More than 15 years	24	22.0
Missing data	16	14.7
Can talk with youth about birth control		
Yes	80	73.4
No	2	1.8
Missing data	27	24.8

Table 6 provides additional information about the child welfare workers in the three DCFS regions who completed the pretraining survey. We focus on differences between child welfare workers from the Central region and those from the Northern region or Cook County because only 6 child welfare workers were from the Southern region. The two groups were about as likely to have been in the profession for no more than five years or for more than 15 years. Child welfare workers from the Central region were less likely to report that their agency allowed them to talk with youth in care about birth control than child welfare workers from the Northern region or Cook County. However, data were missing for a large percentage of both groups.

Table 6. Child Welfare Worker Characteristics by DCFS Region

Characteristic	Central (*n* = 53)	Northern/Cook (*n* = 50)	Southern (*n* = 6)
	%	%	%
Years working in child welfare			
No more than 2 years	17.0	8.0	0.0
3 to 5 years	5.7	18.0	16.7
6 to 10 years	24.5	32.0	83.3
11 to 15 years	13.2	4.0	0.0
More than 15 years	22.6	24.0	0.0
Missing data	17.0	14.0	0.0
Can talk with youth about birth control			
Yes	69.8	76.0	83.3
No	1.9	2.0	0.0
Missing data	28.3	22.0	16.7

Knowledge and Attitudes

Caregivers and child welfare workers who completed the pretraining survey were asked to read five statements related to sexual health or development and indicate whether each was true or false. Their responses are shown in Table 7. Almost all the respondents knew that contraceptives do *not* protect against STIs and that childhood trauma can affect the decisions made by youth in care about relationships. However, about a third mistakenly thought that sexual development begins around the time children enter puberty and that youth in care are no more likely than other adolescents to become pregnant.

Table 7. Pretraining Knowledge about Healthy Sexual Development (*N* = 228) [a]

Item	#	%
Sexual development begins around the time children enter puberty. (F)		
True	77	36.8
False	132	63.2
Missing data	19	
Youth in care have a right to receive family planning services beginning at age 12. (T)		
True	181	87.0
False	27	13.0
Missing data	20	
Youth in care are no more likely to become pregnant than other adolescents. (F)		
True	71	33.5
False	141	66.5
Missing data	16	
All contraceptives protect against STIs as well as pregnancy. (F)		
True	7	3.3
False	208	96.7
Missing data	13	
Childhood trauma can affect the decisions youth in care make about relationships. (T)		
True	209	98.6
False	3	1.4
Missing data	16	

[a] The "T" or "F" next to each statement indicates the correct answer.

Table 8 compares how caregivers and child welfare workers responded to the five sexual health or development items. The only difference between the groups is that caregivers were less likely than child welfare workers to know that puberty is *not* when sexual development begins.

Table 8. Pretraining Knowledge about Healthy Sexual Development by Relationship to DCFS[a]

Item	Caregivers (*n* = 119)	Child Welfare Workers (*n* = 97)	*p*[b]
Sexual development begins around the time children enter puberty. (F)			*
True (%)	46.8	26.1	
False (%)	53.2	73.9	
Missing data (*n)*	10	9	
Youth in care have a right to receive family planning services beginning at age 12. (T)			
True (%)	86.0	89.9	
False (%)	14.0	10.1	
Missing data (*n*)	12	8	
Youth in care are no more likely to become pregnant than other adolescents. (F)			
True (%)	32.7	35.6	
False (%)	67.3	64.4	
Missing data (*n*)	9	7	
All contraceptives protect against STIs as well as pregnancy. (F)			
True (%)	4.4	2.2	
False (%)	95.6	97.8	
Missing data (*n*)	6	7	
Childhood trauma can affect the decisions youth in care make about relationships. (T)			
True (%)	97.3	100.0	
False (%)	2.8	0.0	
Missing data (*n*)	10	6	

[a] The "T" or "F" next to each statement indicates the correct answer.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

Caregivers and child welfare workers who completed the posttraining survey were presented with the same five statements about sexual health or development. Their responses are shown in Table 9. The percentage of caregivers and child welfare workers who responded correctly changed very little over time. Even after completing the training, about a third mistakenly thought that sexual development begins around the time children enter puberty and that youth in care are no more likely than other adolescents to become pregnant.

Table 9. Posttraining Knowledge about Healthy Sexual Development (*N* = 218)[a]

Item	#	%
Sexual development begins around the time children enter puberty. (F)		
True	63	32.1
False	133	67.9
Missing data	22	
Youth in care have a right to receive family planning services beginning at age 12. (T)		
True	195	91.5
False	18	8.5
Missing data	5	
Youth in care are no more likely to become pregnant than other adolescents. (F)		
True	79	36.4
False	138	63.6
Missing data	1	
All contraceptives protect against STIs as well as pregnancy. (F)		
True	10	4.7
False	202	95.3
Missing data	6	
Childhood trauma can affect the decisions youth in care make about relationships. (T)		
True	199	92.1
False	17	7.9
Missing data	2	

[a] The "T" or "F" next to each statement indicates the correct answer.

Table 10 shows responses to those five items separately for caregivers and child welfare workers. After completing the training, child welfare workers were still more likely than caregivers to know that puberty is *not* when sexual development begins.

Table 10. Posttraining Knowledge about Healthy Sexual Development by Relationship to DCFS [a, b]

Item	Caregivers (*n* = 102)	Child Welfare Workers (*n* = 68)	*p*[b]
Sexual development begins around the time children enter puberty. (F)			*
True (%)	41.3	14.1	
False (%)	58.7	85.9	
Missing data (*n*)	10	4	
Youth in care have a right to receive family planning services beginning at age 12. (T)			
True (%)	96.0	91.0	
False (%)	4.0	9.0	
Missing data (*n*)	3	1	
Youth in care are no more likely to become pregnant than other adolescents. (F)			
True (%)	34.3	39.7	
False (%)	65.7	60.3	
Missing data (*n*)	0	0	
All contraceptives protect against STIs as well as pregnancy. (F)			
True (%)	5.0	3.0	
False (%)	95.0	97.0	
Missing data (*n*)	2	2	
Childhood trauma can affect the decisions youth in care make about relationships. (T)			
True (%)	93.0	94.1	
False(%)	7.0	5.9	
Missing data (*n*)	2	0	

[a] The "T" or "F" next to each statement indicates the correct answer.
[b] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[c] Statistically significant difference between caregivers and child welfare workers at $p < .05$

Table 11 compares pretraining to posttraining responses from caregivers and child welfare workers to the five sexual health and development items when the analysis is limited to training sessions from which we received both pretraining and posttraining surveys. At the end of the training, participants were more likely to know that youth in care have a right to receive family planning services beginning at age 12. However, they were less likely to know that childhood trauma can affect the decisions youth in care make about relationships.[10]

[10] It is not clear why the percentage of caregivers and child welfare workers who knew that childhood trauma can affect the decisions youth in care make about relationships was lower after the training than before. Possible explanations include differences between the composition of the pretraining and posttraining samples despite our efforts to increase their comparability or the lower rate of nonresponse to this item on the posttraining than on the pretraining survey.

Table 11. Pretraining Compared to Posttraining Knowledge about Healthy Sexual Development[a]

Item	Pre (*n* = 207)	Post (*n* = 184)	*p* [b]
Sexual development begins around the time children enter puberty. (F)			
True (%)	36.3	35.6	
False (%)	63.7	64.4	
Missing data (*n*)	17	21	
Youth in care have a right to receive family planning services beginning at age 12. (T)			*
True (%)	85.6	92.2	
False (%)	14.4	7.8	
Missing data (*n*)	19	4	
Youth in care are no more likely to become pregnant than other adolescents. (F)			
True (%)	32.6	35.0	
False (%)	67.4	65.0	
Missing data (*n)*	14	1	
All contraceptives protect against STIs as well as pregnancy. (F)			
True (%)	2.6	5.6	
False (%)	97.4	94.4	
Missing data (*n)*	12	5	
Childhood trauma can affect the decisions youth in care make about relationships. (T)			*
True (%)	99.0	91.2	
False (%)	1.0	8.8	
Missing data (*n)*	14	2	

[a] The "T" or "F" next to each statement indicates the correct answer.
[a] Statistically significant difference between pretraining and posttraining responses at $p < .05$.

Caregivers and child welfare workers who completed the pretraining survey were presented with seven statements related to talking with youth in care about sexual health asked to indicate whether they "strongly disagreed," "disagreed," "agreed," or "strongly agreed" with each statement. Their responses are shown in Table 12. There was widespread agreement about the need to talk with youth in care about sexual health. However, nearly a quarter of the respondents acknowledged that they would not be able to put their personal values aside.

Table 12. Pretraining Responses to Questions Related to Talking about Sexual Health (*N* = 228)

Item	*n*	%
I should only discuss sexual health with youth in care if they initiate the conversation.		
Agree or strongly agree	29	13.7
Disagree or strongly disagree	182	86.3
Missing data	17	
I only need to have "the talk" once with each youth in care.		
Agree or strongly agree	6	2.9
Disagree or strongly disagree	202	97.1
Missing data	20	
It is better to ignore some questions about sexual health because children are too young to understand the answers.		
Agree or strongly agree	17	8.0
Disagree or strongly disagree	195	92.0
Missing data	16	
Youth in care learn all they need to know about sexual health from sex education classes in school.		
Agree or strongly agree	12	5.7
Disagree or strongly disagree	200	94.3
Missing data	16	
Talking with youth about sex only sends the message that it is okay for them to be having sex.		
Agree or strongly agree	5	2.4
Disagree or strongly disagree	205	97.6
Missing data	18	
I could put my personal values aside when talking with youth about sex health.		
Agree or strongly agree	158	77.1
Disagree or strongly disagree	47	22.9
Missing data	23	
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.		
Agree or strongly agree	188	89.5
Disagree or strongly disagree	22	10.5
Missing data	18	

Table 13 compares how caregivers and child welfare workers responded to the seven statements related to talking with youth in care about sexual health on the pretraining survey. In every case where differences were found, child welfare workers were more likely than caregivers to express support for talking about sexual health with youth in care.

Table 13. Pretraining Responses to Questions Related to Talking about Sexual Health by Relationship to DCFS

Item	Caregivers (*n* = 119)	Child Welfare Workers (*n* = 97)	*p*[a]
I should only discuss sexual health with youth in care if they initiate the conversation.			*
Agree or strongly agree (%)	21.7	5.4	
Disagree or strongly disagree (%)	78.3	94.6	
Missing data (*n*)	13	4	
I only need to have "the talk" once with each youth in care.			*
Agree or strongly agree (%)	5.8	0.0	
Disagree or strongly disagree (%)	94.2	100.0	
Missing data (*n*)	16	4	
It is better to ignore some questions about sexual health because children are too young to understand the answers.			*
Agree or strongly agree (%)	13.2	3.2	
Disagree or strongly disagree (%)	86.8	96.8	
Missing data (*n*)	13	3	
Youth in care learn all they need to know about sexual health from sex education classes in school.			*
Agree or strongly agree (%)	9.1	1.1	
Disagree or strongly disagree (%)	90.9	98.9	
Missing data (*n*)	9	7	
Talking with youth about sex health only sends the message that it is okay for them to be having sex.			*
Agree or strongly agree (%)	4.8	0.0	
Disagree or strongly disagree (%)	95.2	100.0	
Missing data (*n*)	14	4	
I could put my personal values aside when talking with youth about sex health.			*
Agree or strongly agree (%)	69.2	85.4	
Disagree or strongly disagree (%)	30.8	14.6	
Missing data (*n*)	15	8	
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.			
Agree or strongly agree (%)	87.7	91.3	
Disagree or strongly disagree (%)	12.3	8.7	
Missing data (*n*)	13	5	

[a] Statistically significant difference between caregivers and child welfare workers at $p < .05$

Table 14 shows how caregivers and child welfare workers responded to those same seven statements on the posttraining survey. Once again, there was widespread agreement about the need to talk with youth in care about sexual health. However, 16 percent of the respondents continued to acknowledge that they would not be able to put their personal values aside.

Table 14. Posttraining Responses to Questions Related to Talking about Sexual Health (*N* = 218)

Item	*n*	%
I should only discuss sexual health with youth in care if they initiate the conversation.		
Agree or strongly agree	19	8.8
Disagree or strongly disagree	196	91.2
Missing data	3	
I only need to have "the talk" once with each youth in care.		
Agree or strongly agree	8	3.7
Disagree or strongly disagree	207	96.3
Missing data	3	
It is better to ignore some questions about sexual health because children are too young to understand the answers.		
Agree or strongly agree	10	4.6
Disagree or strongly disagree	206	95.4
Missing data	2	
Youth in care learn all they need to know about sexual health from sex education classes in school.		
Agree or strongly agree	6	2.8
Disagree or strongly disagree	210	97.2
Missing data	2	
Talking with youth about sex only sends the message that it is okay for them to be having sex.		
Disagree or strongly disagree	11	5.2
Agree or strongly agree	202	94.8
Missing data	5	
I could put my personal values aside when talking with youth about sex health.		
Agree or strongly agree	180	84.1
Disagree or strongly disagree	34	15.9
Missing data	4	
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.		
Agree or strongly agree	161	89.4
Disagree or strongly disagree	19	10.6
Missing data	38	

Table 15 compares how caregivers and child welfare workers responded to those seven statements on the posttraining survey. There were fewer differences between the groups on the posttraining survey than there had been on the pretraining survey, and the differences that did exist were relatively small.

Table 15. Posttraining Responses to Questions Related to Talking about Sexual Health by Relationship to DCFS[a]

Item	Caregivers (*n* = 102)	Child Welfare Workers (*n* = 68)	*p*[b]
I should only discuss sexual health with youth in care if they initiate the conversation.			
Agree or strongly agree (%)	14.0	6.0	
Disagree or strongly disagree (%)	86.0	94.0	
Missing data (*n*)	2	1	
I only need to have "the talk" once with each youth in care.			
Agree or strongly agree (%)	5.0	1.5	
Disagree or strongly disagree (%)	95.0	98.5	
Missing data (*n*)	2	0	
It is better to ignore some questions about sexual health because children are too young to understand the answers.			*
Agree or strongly agree (%)	6.9	0.0	
Disagree or strongly disagree (%)	93.1	100.0	
Missing data (*n*)	1	1	
Youth in care learn all they need to know about sexual health from sex education classes in school.			
Agree or strongly agree (%)	5.0	0.0	
Disagree or strongly disagree (%)	95.1	100.0	
Missing data (*n*)	1	0	
Talking with youth about sex only sends the message that it is okay for them to be having sex.			*
Agree or strongly agree (%)	7.1	0.0	
Disagree or strongly disagree (%)	92.9	100.0	
Missing data (*n*)	4	1	
I could put my personal values aside when talking with youth about sex health.			
Agree or strongly agree (%)	82.0	87.9	
Disagree or strongly disagree (%)	18.0	12.1	
Missing data (*n*)	2	2	
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.			
Agree or strongly agree (%)	85.1	93.3	
Disagree or strongly disagree (%)	14.9	6.7	
Missing data (*n*)	15	8	

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$

Table 16 compares pretraining to posttraining responses to those seven statements from caregivers and child welfare workers when the analysis was limited to training sessions from which we received both pretraining and posttraining surveys. In general, there was relatively little change over time in the percentage who agreed about the need to talk with youth in care about sexual health. However, the percentage of respondents who believed they could put their personal values aside when talking with youth about sex health rose by six percentage points.

Table 16. Pretraining Compared to Posttraining Responses to Questions Related to Talking about Sexual Health

Item	Pretraining (n = 207)	Posttraining (n = 184)	p[a]
I should only discuss sexual health with youth in care if they initiate the conversation.			
Agree or strongly agree (%)	13.5	8.8	
Disagree or strongly disagree (%)	86.5	91.2	
Missing data (n)	14	2	
I only need to have "the talk" once with each youth in care.			
Agree or strongly agree (%)	2.6	3.9	
Disagree or strongly disagree (%)	97.4	96.1	
Missing data (n)	15	3	
It is better to ignore some questions about sexual health because children are too young to understand the answers.			
Agree or strongly agree (%)	7.8	5.5	
Disagree or strongly disagree (%)	92.2	94.5	
Missing data (n)	14	1	
Youth in care learn all they need to know about sexual health from sex education classes in school.			
Agree or strongly agree (%)	5.7	3.3	
Disagree or strongly disagree (%)	94.3	96.7	
Missing data (n)	14	2	
Talking with youth about sex only sends the message that it is okay for them to be having sex.			
Agree or strongly agree (%)	2.1	5.6	
Disagree or strongly disagree (%)	97.9	94.4	
Missing data (n)	16	4	
I could put my personal values aside when talking with youth about sex health.			
Agree or strongly agree (%)	77.5	83.9	
Disagree or strongly disagree (%)	22.5	16.1	
Missing data (n)	20	4	
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.			
Agree or strongly agree (%)	89.1	88.4	
Disagree or strongly disagree (%)	10.9	11.6	
Missing data (n)	15	37	

[a] Statistically significant difference between pretraining and posttraining responses at $p < .05$.

Caregivers and child welfare workers who completed the pretraining survey were asked if it is healthy for youth to question or experiment with their sexual orientation. Their responses are shown in Table 17. Eighty-two percent of the respondents agreed or strongly agreed that experimentation is healthy for youth. However, caregivers were significantly less likely than child welfare workers to agree or strongly agree.

Table 17. Pretraining Beliefs about Experimentation with Sexual Orientation

Item	Total (*N* = 203)	Caregivers (*n* = 104)	Child Welfare Workers (*n* = 87)	*p*[a]
It is healthy for youth to question or experiment with their sexual orientation				*
Agree or strongly agree (%)	82.3	69.2	95.4	
Disagree or strongly disagree (%)	18.7	30.8	4.6	
Missing data (*n*)	25	15	10	

[a] Statistically significant difference between caregivers and child welfare workers at $p < .05$

Caregivers and child welfare workers who completed the posttraining survey were asked the same question. Their responses are shown in Table 18. Three quarters agreed or strongly agreed that it is healthy for youth to question or experiment with their sexual orientation. This is lower than the percentage who had agreed or strongly agreed on the pretraining survey, but there was much less missing data. Moreover, although caregivers were still less likely than child welfare workers to agree or strongly agree, the difference between them was no longer statistically significant.

Table 18. Posttraining Beliefs about Experimentation with Sexual Orientation[a]

Item	Total (*N* = 214)	Caregivers (*n* = 100)	Child Welfare Workers (*n* = 67)	*p*
It is healthy for youth to question or experiment with their sexual orientation				
Agree or strongly agree (%)	75.2	73.0	85.1	
Disagree or strongly disagree (%)	24.8	27.0	14.9	
Missing data (*n*)	4	2	1	

[a] Caregiver and child welfare worker data do not include 48 individuals whose relationship to DCFS could not be determined.

Table 19 compares pretraining and posttraining responses from caregivers and child welfare workers to the question about whether it is healthy for youth to question or experiment with their sexual orientation when the analysis was limited to training sessions from which we received both pretraining and posttraining surveys. The percentage of caregivers and child welfare workers who agreed that that it is healthy for youth to question or experiment with their sexual orientation was higher before than after the training.[11]

Table 19. Pretraining Compared to Posttraining Beliefs about Experimentation with Sexual Orientation

Item	Pretraining (*n* = 207)	Posttraining (*n* = 184)
It is healthy for youth to question or experiment with their sexual orientation		
Disagree or strongly disagree (%)	18.4	26.7
Agree or strongly agree (%)	81.6	73.3
Missing data (*n*)	22	4

[11] It is not clear why the percentage of caregivers and child welfare workers who agreed or strongly agreed that experimentation with their sexual orientation is healthy for youth was higher before the training than after. Possible explanations include differences between the composition of the pretraining and posttraining samples despite our efforts to make increase their comparability or the lower rate of nonresponse to this item on the posttraining than on the pretraining survey.

Experiences Talking with Youth in Care about Healthy Sexual Development

Caregivers and child welfare workers who completed the pretraining survey were presented with a list of nine topics related to sexual health or development and asked to indicate whether they had ever talked with a youth in care about those topics. Their responses, which are shown in Table 20, suggest that caregivers and child welfare workers were least likely to have talked about masturbation or gender identity and most likely to have talked about healthy relationships, sexual abuse, or puberty with a youth in care.

Table 20. Ever Talked with Youth in Care about Sexual Health Topics (*N* = 228)

Topic	*N*	%
Puberty and physical changes		
Yes	147	73.1
No	54	26.9
Missing data	27	
Healthy romantic and sexual relationships		
Yes	151	72.6
No	57	27.4
Missing data	20	
Masturbation		
Yes	85	42.1
No	117	57.9
Missing data	26	
Sexual orientation		
Yes	134	65.7
No	70	34.3
Missing data	24	
Gender identity		
Yes	99	48.8
No	104	51.2
Missing data	25	
Contraception/birth control		
Yes	140	69.3
No	62	30.7
Missing data	26	
STI or HIV/AIDS prevention		
Yes	139	68.8
No	63	31.2
Missing data	26	
Peer pressure to engage in sexual behavior		
Yes	140	69.3
No	62	30.7
Missing data	26	
Sexual content in popular culture		
Yes	133	67.2
No	65	32.8
Missing data	30	
Sexual abuse		
Yes	151	73.3
No	55	26.7
Missing data	22	
Pregnancy and child birth		
Yes	140	71.4
No	56	28.6
Missing data	32	

Table 21 compares how caregivers and child welfare workers responded to that list of nine topics. Where differences were found, child welfare workers were more likely than caregivers to have talked with a youth in care about the topic.

Table 21. Ever Talked with Youth in Care about Sexual Health Topics by Relationship with DCFS

Topic	Caregivers (*n* = 119)	Child Welfare Workers (*n* = 97)	*p* [a]
Puberty and physical changes			*
Yes (%)	79.2	65.2	
No (%)	20.8	34.8	
Missing data (*n*)	18	8	
Healthy romantic and sexual relationships			*
Yes (%)	63.8	80.2	
No (%)	36.2	19.8	
Missing data (*n*)	14	6	
Masturbation			*
Yes (%)	33.7	47.8	
No (%)	66.3	52.2	
Missing data (*n*)	18	7	
Sexual orientation			
Yes (%)	60.6	70.8	
No (%)	39.4	29.2	
Missing data (*n*)	15	8	
Gender identity			
Yes (%)	51.0	45.6	
No (%)	49.0	54.4	
Missing data (*n*)	17	7	
Contraception/birth control			*
Yes (%)	60.0	78.9	
No (%)	40.0	21.1	
Missing data (*n*)	19	7	
STI or HIV/AIDS prevention			
Yes (%)	62.4	74.4	
No (%)	37.6	25.6	
Missing data (*n*)	18	7	
Peer pressure to engage in sexual behavior			
Yes (%)	66.0	71.1	
No (%)	34.0	28.9	
Missing data (*n*)	19	7	
Sexual content in popular culture			
Yes (%)	69.0	63.2	
No (%)	31.0	36.8	
Missing data (*n*)	19	10	
Sexual abuse			
Yes (%)	68.3	77.8	
No (%)	31.7	22.2	
Missing data (*n*)	15	7	
Pregnancy and child birth			
Yes (%)	67.0	75.9	
No (%)	33.0	24.1	
Missing data (*n*)	22	10	

[a] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

Caregivers and child welfare workers were also asked to rate how comfortable they would feel talking with a youth in care about each of those nine topics using a four-point scale that ranged from 1 (not at all

comfortable) to 4 (very comfortable). Their responses, which are shown in Table 22, suggest that caregivers and child welfare workers would feel least comfortable talking about masturbation and most comfortable talking about peer pressure or sexual content in popular culture with a youth in care.

Table 22. Pretraining Comfort Level with Talking about Sexual Health Topics (*N* = 228)

Topic	*n*	Mean	SD
Puberty and physical changes	215	3.6	0.63
Healthy romantic and sexual relationships	214	3.7	0.60
Masturbation	212	2.9	1.05
Sexual orientation or gender identity	213	3.4	0.76
Gender identity	206	3.4	0.79
Contraception/birth control	213	3.7	0.58
STI or HIV/AIDS prevention	212	3.7	0.54
Peer pressure to engage in sexual behavior	209	3.8	0.48
Sexual content in popular culture	210	3.8	0.48
Sexual abuse	213	3.6	0.60
Pregnancy and child birth	214	3.7	0.69

Table 23 compares how caregivers and child welfare workers responded to the comfort level questions. Child welfare workers consistently reported feeling more comfortable talking about these topics with a youth in care than caregivers.

Table 23. Pretraining Comfort Level with Talking about Sexual Health Topics by Relationship to DCFS

Topic	Caregivers			Child Welfare Workers			
	n	Mean	SD	*n*	Mean	SD	*p* [a]
Puberty and physical changes	111	3.5	0.69	92	3.6	0.57	
Healthy romantic and sexual relationships	111	3.6	0.71	91	3.8	0.46	*
Masturbation	107	2.8	1.06	93	3.0	1.05	
Sexual orientation or gender identity	109	3.3	0.85	93	3.5	0.65	*
Gender identity	106	3.3	0.86	89	3.5	0.71	*
Contraception/birth control	111	3.6	0.71	90	3.9	0.35	*
STI or HIV/AIDS prevention	109	3.7	0.61	91	3.8	0.47	
Peer pressure to engage in sexual behavior	107	3.7	0.57	91	3.9	0.35	*
Sexual content in popular culture	108	3.6	0.55	92	3.8	0.39	*
Sexual abuse	109	3.5	0.69	92	3.7	0.49	*
Pregnancy and child birth	111	3.6	0.74	91	3.7	0.65	

[a] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

After completing training, caregivers and child welfare workers were once again asked how comfortable they would feel talking with a youth in care about those nine topics. Their responses, which are shown in Table 24, are largely consistent with responses on the pretraining survey. Caregivers and child welfare workers reported feeling least comfortable talking with youth in care about masturbation and most comfortable talking with youth in care about peer pressure, sexual content in popular culture, and STI or HIV/AIDS prevention.

Table 24. Posttraining Comfort Level with Talking about Sexual Health Topics (*N* = 218)

Topic	*n*	Mean	SD
Puberty and physical changes	212	3.5	0.87
Healthy romantic and sexual relationships	213	3.7	0.56
Masturbation	212	3.2	0.87
Sexual orientation or gender identity	214	3.5	0.74
Gender identity	210	3.4	0.70
Contraception/birth control	212	3.7	0.54
STI or HIV/AIDS prevention	212	3.8	0.54
Peer pressure to engage in sexual behavior	214	3.8	0.50
Sexual content in popular culture	210	3.8	0.51
Sexual abuse	213	3.6	0.66
Pregnancy and child birth	213	3.7	0.62

Table 25 compares how caregivers and child welfare workers responded to the comfort level questions. Although child welfare workers consistently reported feeling more comfortable than caregivers on the pre-training survey, those differences had largely disappeared on the posttraining survey.

Table 25. Posttraining Comfort Level with Talking about Sexual Health Topics by Relationship to DCFS[a]

Topic	Caregivers			Child Welfare Workers			
	n	Mean	SD	*n*	Mean	SD	*p*[b]
Puberty and physical changes	98	3.5	0.76	67	3.5	0.84	
Healthy romantic and sexual relationships	100	3.7	0.61	67	3.7	0.47	
Masturbation	99	3.2	0.88	66	3.2	0.82	
Sexual orientation or gender identity	100	3.4	0.79	67	3.6	0.61	
Gender identity	96	3.4	0.73	67	3.5	0.66	
Contraception/birth control	100	3.7	0.56	67	3.8	0.45	
STI or HIV/AIDS prevention	99	3.7	0.61	67	3.8	0.42	
Peer pressure to engage in sexual behavior	99	3.8	0.52	68	3.8	0.43	
Sexual content in popular culture	97	3.7	0.57	67	3.8	0.37	
Sexual abuse	101	3.6	0.73	67	3.6	0.55	
Pregnancy and child birth	101	3.7	0.70	66	3.7	0.51	

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$

Table 26 compares pretraining to posttraining responses from caregivers and child welfare workers to the comfort level questions. To make the pretraining sample as comparable as possible to the posttraining sample, we limited the analysis to training sessions from which we received both pretraining and posttraining surveys. Although there was relatively little change in comfort levels over time, where differences were found comfort levels were higher after completing the training than before.

Table 26. Pretraining Compared to Posttraining Comfort Level with Talking about Sexual Health Topics

Topic	Pretraining			Posttraining			
	n	Mean	SD	*n*	Mean	SD	*p*[a]
Puberty and physical changes	195	3.6	0.63	178	3.4	0.89	*
Healthy romantic and sexual relationships	195	3.7	0.60	180	3.7	0.58	
Masturbation	192	2.9	1.05	178	3.2	0.87	*
Sexual orientation or gender identity	194	3.4	0.76	180	3.5	0.76	
Gender identity	188	3.4	0.80	178	3.4	0.70	
Contraception/birth control	195	3.7	0.57	179	3.7	0.56	
STI or HIV/AIDS prevention	193	3.7	0.53	180	3.7	0.56	
Peer pressure to engage in sexual behavior	189	3.8	0.45	181	3.8	0.52	
Sexual content in popular culture	191	3.8	0.46	177	3.8	0.53	
Sexual abuse	194	3.6	0.58	181	3.6	0.66	
Pregnancy and child birth	195	3.7	0.68	181	3.7	0.64	

[a] Statistically significant difference between pretraining and posttraining responses at $p < .05$.

Ratings of Training and Trainers

After completing training, caregivers and child welfare workers were asked to rate the training and the trainers along a number of dimensions, using a four-point scale that ranged from strongly disagree (1) to strongly agree (4). Their responses are shown in Table 27. All the means fell between 3.3 and 3.6, suggesting that views of both the training and the trainers were generally positive.

Table 27. Ratings of Training and the Trainers

Item	*N*	Mean	SD
Trainers know a lot about the subject.	169	3.5	0.56
Trainers presented the material clearly.	168	3.6	0.53
Plan to use what I learned from this training.	168	3.5	0.58
Learned a lot from this training.	166	3.3	0.71
Trainers did a good job of answering questions.	169	3.6	0.53
I would attend future trainings on this subject.	167	3.4	0.73
Felt comfortable sharing my opinions	170	3.6	0.57
Trainers respected what I had to say.	169	3.6	0.55
Training made me think about personal values	169	3.4	0.63

Table 28 compares the mean ratings given by the caregivers to those given by the child welfare workers. Caregivers tended to rate the trainers and training more highly than child welfare workers, but only two of those differences were statistically significant.

Table 28. Ratings of Training and the Trainers by Relationship to DCFS[a]

Item	Caregivers			Child Welfare Workers			
	n	Mean	SD	*n*	Mean	SD	*p*[b]
Trainers know a lot about the subject.	90	3.6	0.57	45	3.5	0.55	
Trainers presented the material clearly.	91	3.7	0.54	45	3.5	0.50	
I plan to use what I learned from this training.	91	3.6	0.58	45	3.4	0.55	
I learned a lot from this training.	89	3.3	0.77	45	3.1	0.65	
Trainers did a good job of answering questions.	91	3.6	0.55	45	3.4	0.50	*
I would attend future trainings on this subject.	89	3.5	0.62	45	3.1	0.81	*
I felt comfortable sharing my opinions	91	3.7	0.56	45	3.5	0.50	
Trainers respected what I had to say.	90	3.7	0.58	45	3.6	0.50	
Training made me think about personal values	91	3.5	0.64	44	3.3	0.64	

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

Caregivers and child welfare workers who completed the posttraining survey were also asked to indicate how much they had learned from the training and to share their opinions about the length of the training and its difficulty level. Their responses are shown in Table 29. Respondents were about evenly split between those who learned about as much as they had expected and those whose expectations for what they would learn were exceeded. Almost 70 percent thought the 6-hour training was too short and about 80 percent thought the difficulty level was just right. Although this feedback was quite positive, data were missing for nearly a quarter of the sample.

Table 29. Opinions about Training

Item	*n*	%
Training taught me…		
Less than I expected	11	6.5
About as much as I expected	80	47.6
More than I expected	77	45.8
Missing data	50	
Training was…		
Too short	116	69.0
Just the right length	22	13.1
Too long	30	17.9
Missing data	50	
Training was…		
Too basic	32	18.9
Right level	136	80.5
Too advanced	1	0.6
Missing data	49	

Table 30 compares the responses given by the caregivers to those given by the child welfare workers. Compared to child welfare workers, caregivers were more likely to have learned more than they had expected from the training and to have thought that the training was just the right length.

Table 30. Opinions about Training by Relationship to DCFS[a]

Item	Caregivers (*n* = 102)	Child Welfare Workers (*n* = 68)	*p*[b]
Training taught me…			*
Less than expected (%)	5.9	9.1	
As much as expected (%)	40.0	59.1	
More than expected (%)	54.1	31.8	
Missing data (*n*)	17	24	
Training was…			*
Too short (%)	65.9	76.7	
Right length (%)	21.2	0.0	
Too long (%)	12.9	23.3	
Missing data (*n*)	17	25	
Training was…			
Too basic (%)	15.3	29.6	
Right level (%)	84.7	70.5	
Too advanced (%)	0.0	0.0	
Missing data (*n*)	17	24	

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

In addition to rating the training overall, caregivers and child welfare workers were also asked to rate how much they had learned from each of 15 activities, using a 5-point scale that ranged from nothing (1) to a lot (5). Their responses are shown in Table 31. The means ranged from 3.0 to 3.5, which corresponds to learning a moderate amount. The highest rating was given to the New Jargon activity.

Table 31. Ratings of Activities

Item	*n*	Mean	SD
Day One Activities			
Crucial Connection video	143	3.3	0.75
Agree/disagree	157	3.1	0.90
True/false quiz	162	3.2	0.79
Sex Bingo	152	3.1	0.92
Where Do You Stand? Sexuality opinion survey	153	3.1	0.86
Under Your Hat	151	3.3	0.76
New Jargon activity	153	3.5	0.77
Homework	141	3.0	0.93
Day Two Activities			
True/false quiz	168	3.0	0.90
Create a Definition of Healthy Sexuality for Youth	166	3.1	0.88
What Is Love?: Youth perceptions	166	3.2	0.78
Love, Lust, or Rebounding?	165	3.2	0.83
Role playing exercise	153	3.1	0.95
Naming contraceptives	153	3.0	0.96
Window of Opportunity activity	152	3.3	0.79

Table 32 compares the mean ratings of the activities given by caregivers to those given by child welfare workers. Caregivers reported learning more from 11 of the 15 activities than child welfare workers.

Table 32. Ratings of Activities by Relationship to DCFS[a]

Item	Caregivers			Child Welfare Workers			
	n	Mean	SD	*n*	Mean	SD	*p*[b]
Day One Activities							
Crucial Connection video	76	3.5	0.62	37	3.1	0.86	*
Agree/disagree	81	3.3	0.74	40	3.0	0.99	*
True/false quiz	83	3.4	0.66	40	3.1	0.81	*
Sex Bingo	81	3.3	0.85	37	2.9	0.98	*
Where Do You Stand? sexuality opinion survey	83	3.2	0.89	34	3.1	0.83	
Under Your Hat	77	3.5	0.70	39	3.2	0.71	
New Jargon activity	79	3.6	0.65	41	3.5	0.84	
Homework	75	3.0	0.94	34	2.7	0.99	
Day Two Activities							
True/false quiz	88	3.2	0.80	41	2.7	1.02	*
Create a Definition of Healthy Sexuality for Youth	88	3.3	0.80	44	2.9	0.92	*
What Is Love?: Youth perceptions	87	3.4	0.67	42	3.0	0.81	*
Love, Lust, or Rebounding?	87	3.5	0.61	40	2.8	0.98	*
Role playing exercise	80	3.2	0.95	38	2.7	0.93	*
Naming contraceptives	78	3.2	0.85	40	2.5	1.09	*
Window of Opportunity activity	80	3.4	0.65	38	3.0	0.85	*

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

Caregivers and child welfare workers who completed the posttraining survey were asked to indicate whether they would recommend the training to their peers and whether attending the training with both caregivers and child welfare workers made them feel uncomfortable. Their responses are shown in Table 33. The vast majority of both groups would recommend the training and only one in five reported that having both caregivers and child welfare workers present made them feel less comfortable.

Table 33. Caregiver and Child Welfare Worker Recommendations about the Training

Item	#	%
Would recommend training to other caregivers[a]		
Disagree or strongly disagree	7	5.9
Agree or strongly agree	111	94.1
Missing	14	
Would have felt more comfortable if training were only for caregivers[a]		
Disagree or strongly disagree	86	82.7
Agree or strongly agree	18	17.3
Missing	28	
Would recommend training to other child welfare workers[b]		
Disagree or strongly disagree	5	7.0
Agree or strongly agree	66	93.0
Missing	27	
Would have felt more comfortable if training were only for child welfare workers[b]		
Disagree or strongly disagree	57	79.2
Agree or strongly agree	15	20.8
Missing	26	

[a] Asked only of caregivers.
[b] Asked only of child welfare workers.

The Department maintains a Virtual Training Center (VTC) that allows caregivers and child welfare workers to access training materials and training-related resources online. Caregivers and child welfare workers who completed the posttraining survey were asked a series of questions about the VTC. Their responses are shown in Table 34. Most caregivers and child welfare workers who responded to the questions reported knowing both how to access information through the VTC and what resources can be accessed. Nearly two-thirds of the respondents had already accessed resources through the VTC and almost all planned to do so in the future. However, only 42 percent of the respondents had accessed resources with a youth in care.

Table 34. Survey Responses about Knowledge and Use of VTC

Item	*n*	%
Know how to access information through the VTC		
Disagree or strongly disagree	16	9.6
Agree or strongly agree	151	90.4
Missing data	51	
Know what information I can access through the VTC		
Disagree or strongly disagree	18	10.8
Agree or strongly agree	149	89.2
Missing data	51	
Have already accessed resources through the VTC		
No	58	35.2
Yes	107	64.9
Missing data	53	
Have accessed VTC resources with a youth in care		
No	90	58.4
Yes	64	41.6
Missing data	64	
Plan to access information through the VTC in the future		
Disagree or strongly disagree	15	9.3
Agree or strongly agree	146	90.7
Missing data	57	

Table 35 compares responses to the VTC questions given by caregivers to those given by child welfare workers. Child welfare workers were more likely than caregivers to know how to access information through the VTC, to have accessed resources through the VTC before, and to have done so with a youth in care. Although child welfare workers were more likely than caregivers to have plans to access information through the VTC in the future, this difference was not statistically significant.

Table 35. Knowledge and Use of VTC by Relationship to DCFS[a]

Item	Caregivers (*n* = 102)	Child Welfare Workers (*n* = 68)	*p* [b]
Know how to access information through the VTC			*
Disagree or strongly disagree (%)	15.3	2.3	
Agree or strongly agree (%)	84.7	97.7	
Missing data (*n*)	17	24	
Know what information I can access through the VTC			
Disagree or strongly disagree (%)	14.3	9.1	
Agree or strongly agree (%)	85.7	90.9	
Missing data (*n*)	18	24	
Have already accessed resources through the VTC			*
No (%)	54.2	15.9	
Yes (%)	45.8	84.1	
Missing data (*n*)	19	24	
Have accessed VTC resources with a youth in care			*
No (%)	73.4	46.2	
Yes (%)	26.6	53.9	
Missing data (*n*)	23	29	
Plan to access information through the VTC in the future			
Disagree or strongly disagree (%)	13.3	4.8	
Agree or strongly agree (%)	86.8	95.2	
Missing data (*n*)	19	26	

[a] Table does not include data for 48 individuals whose relationship to DCFS could not be determined.
[b] Statistically significant difference between caregivers and child welfare workers at $p < .05$.

Caregiver and Child Welfare Worker Interviews

We were not able to interview as many or as diverse a sample of caregivers and child welfare workers as we had hoped. However, the responses of those with whom we did speak provide information about the experiences of the caregivers and child welfare workers who completed the training that the survey data did not capture as well as information about how caregivers and child welfare workers are applying what they learned and how the training might be improved. That said, we recognize that the experiences of the caregivers and child welfare workers we interviewed may not represent the experiences of all the caregivers and child welfare workers who completed the training. Moreover, the small size of our sample precludes drawing any conclusions about regional differences in the experiences of the caregivers and child welfare workers who completed the training from being drawn.

Class Size

All the caregivers and child welfare workers we interviewed attended trainings with fewer than eight participants.[12] Although we don't know how their experiences may have differed from the experiences of caregivers and child welfare workers who attended trainings with more participants, having a small group does not appear to have inhibited discussion. On the contrary, smaller classes may have some advantages. As one caregiver noted:

> We were a very small class and had a different experience than people who may have had a larger class. There's a value to these classes being not too big. People don't feel comfortable sharing and talking… anything much over 10 would be too big. I think optimal would be 6–10.

[12] To put this in perspective, the average class size between April 2013 and January 2014 was 8.4 on day one of the training and 7.6 on day two of the training.

That said, at least one of the caregivers we interviewed was disheartened by the low turnout, particularly given that the child welfare agency where the training was held serves adolescents.

> To be really truthful I was disappointed when I got there and there was only four people at the training. I felt like there should have been a whole lot more especially with the agency we deal with having teenage kids.

Training Caregivers and Child Welfare Workers Together

As we already noted, one of the unique features of this training is that caregivers and child welfare workers attended the sessions together. Hence, we were especially interested in what caregivers and child welfare workers thought about this approach. Although some of the individuals we interviewed attended trainings that did not include both caregivers and child welfare workers, none believed that caregivers and child welfare workers *should* be trained separately. On the contrary, training caregivers and child welfare workers together was perceived as beneficial because it would provide an opportunity for both groups to learn about the challenges their counterparts faced and to share some of the strategies they use to deal with those challenges. As one caregiver put it:

> I do believe child welfare workers and caregivers should be trained together. From the standpoint of caregivers we can benefit from hearing from the child welfare workers about the challenges you've encountered. Good for social workers to learn from caregivers about how we deal with these things as parents.

A similar sentiment was expressed by one child welfare worker.

> I just think at that point [parents] could see what [workers] are expected to do. And workers are able to see the positives and challenges of having a youth in the home.

Caregivers and child welfare workers also saw the training as a chance to help one another better understand what they perceived their respective roles to be when it came to educating youth about sexual health and making healthy choices about their sexual behavior.

Motivation

Caregivers and child welfare workers were asked what had motivated them to attend this particular training. A number of caregivers hoped the training would prepare them should a child who acts out sexually be placed in their care. In the words of one caregiver, "I thought it would be a good class in case I had any children placed with me that had sexual aggression or other kind of sexual behaviors."

Another caregiver was motivated to attend out of a desire to learn about the sexual behaviors youth are engaging in today.

> I'm 61 years old and things are a whole heck of a lot different now than what they were when I was a teenager growing up and the sexual activity of the kids now is totally different. And we decided that we needed to learn.

Child welfare workers reported somewhat different motivations. In one case, the training had been recommended by a supervisor.

> It was recommended by my supervisor that I attend, because I'm senior staff. It's relevant to our work in terms of kids being in foster care and having issues with their sexuality and possibly also sexual abuse... I also saw [the training] on the VTC.

Others attended the training because it was new. One was curious about all the excitement surrounding this particular training.

> It's new. I like to see what it's all about when we offer a new training. One of the trainers. . .she was very excited about it. . . .When the new schedules come out, our training coordinators talk about what's been developed but they were. . .excited to be putting this out.

Another wanted to attend the training before she referred any foster parents to it.

> I try to go to a lot of trainings. I don't like to refer parents to a training I haven't attended.

Expectations

Although the training was clearly described as being about "sexual development, pregnancy, and STI prevention," almost all the caregivers and child welfare workers we spoke with were expecting the training to focus on how to deal with children who had been sexually abused or who were acting out sexually. As one caregiver put it,

> I thought it would be a good class in case I had any children placed with me that had sexual aggression or other kind of sexual behaviors.

Need for the Training

Although it was not something we specifically asked about, more than one of child welfare workers we spoke with commented on why this type of training is needed. As one child welfare worker noted:

> I think sometimes we don't offer enough boots on the ground training for [our foster families with teenage kids]. . . . Sometimes we need to be pretty frank with our foster parents about the kinds of kids and the kinds of activities they're engaging in.

A similar point was made by another child welfare worker who said:

> [Foster families] need to be realistic, frank, not judging per se but managing the kids they have in their home and bring it to the level that [the foster child] is at. . . [the] foster family doesn't have the same compass.

The caregivers we interviewed also perceived a need for this type of training. One of the reasons cited was the difficulty people have talking about issues related to sex or sexuality. As one caregiver put it:

> We as a society have been conditioned not to talk about it. We need to have frank open discussions. If they can't do it with people who are adults how can they do it with children in the home? . . . Here are tips on how you bring up the issue or advance the issue here are questions you can ask. . . . Especially because it's such a taboo for many of our foster families.

Perhaps the best example of why this type of training is so important was provided by one of the child welfare workers:

> For instance in my training there were some foster parents, very seasoned, 20 years I think, she'd never seen a condom before. The trainers put condoms out in front of everyone's chair and she actually thought it was candy. . . so just in those instances. . . they may not offer condoms to their foster kids or talk to them about healthy sexual relationships.

Content of the Training

Although it was not what they had expected, caregivers and child welfare workers valued the "straightforward" manner in which the information on sexual development, pregnancy prevention and healthy relationships was presented. As one child welfare worker reported:

> [The training] was beyond my expectations. It went over and beyond foster kids being abused. Their feelings, why they may have sexual acting out, why they may have relationship issues.

Both caregivers and child welfare workers mentioned being surprised by the increased risk for pregnancy and STIs among youth in care. As one caregiver put it:

> I like the facts that were shared, talking about the number of teen pregnancies that are foster kids and talking about sexual development, the age groups. . .not really a thing I had really thought about but [the rates of teen pregnancy] were astonishing.

This child welfare worker had a very similar response:

> [I liked] all the information. I already use specifics and examples [in my work]. I didn't realize how being a foster kid increases your risk of getting pregnant.

Comments on Activities

We asked the caregivers and child welfare workers to share their thoughts about the various activities in which they had participated over the course of the two-day training. Some of the caregivers had a very positive reaction to the activities.

> There was an activity where you kind of thought about a statement as if you were a 12 year old. That was useful. And that was a point of discussion.

> There was one activity that they handed us out cards. Little index cards and it had a slang word written on it and we were supposed to try to figure out what it meant. . . . And when they handed out these cards none of us had any idea of what these things meant. . . . It was very eye opening.

The reaction of some child welfare workers was also very positive.

> [The training was] more fun than I thought it would be. Lots of different techniques to keep you engaged. . . . Sex bingo, modern music videos.

> I liked the activity about the age appropriate behaviors and specifics ages. They had put age groups around the room and gave you some scenarios of what kids at that age should be doing, whether it's exploring their body, whether it's should be having a conversation about sex. I liked that activity.

However, at least one caregiver didn't think the activities were particularly good use of training time.

> Part of what was covered was lyrics of songs. I didn't think that was helpful as that's something I'm cognizant about anyway. I didn't think that was helpful. . . [I didn't like] Sex Bingo. I didn't think that was very useful. The pictures were confusing and it seemed silly. Maybe if they had actually shown contraception.

Some of the activities elicited particularly strong reactions. For example, one caregiver was struck by the sexual content of the lyrics that were played.

> I found out a whole lot more things than what I was expecting to hear. . . . We were handed out rap that was printed out and we listened to it and god, the sexual orientation of several of the rap songs that were being played. . . I don't know why kids want to listen to that.

This same caregiver found the jargon activity to be "very eye opening."

> People need to see what's going on with these kids. . . . With the way they turn things as a totally different meaning than what us old timers take it for. It's like they have their own code.

Personal Values

We asked the caregivers and child welfare workers we interviewed if the training conflicted in any way with their personal values. One caregiver acknowledged a conflict between his personal values and the beliefs described as prevalent among youth.

> The materials conflicted with my beliefs. You know it showed the way it is now. And that is I'm not against anything the way it was given to us. It's just that the kids' beliefs now and my beliefs are totally opposite.

However, he also recognized that learning about "the kids' beliefs" would help him relate better to youth in his care.

None of the child welfare workers reported any inconsistencies between their personal values and the training. On the contrary, several noted how their personal beliefs were aligned with some of the objectives. In particular, they believed it was important to communicate openly with youth in care about sex and sexuality so that sex and sexuality would be perceived as a healthy part of adult life rather than a source of guilt or shame. Child welfare workers also believed it was important to educate youth about contraception and STI protection (including where and how to obtain birth control).

Although none of the child welfare workers we talked with perceived a conflict between the training and their personal values, several could imagine situations where foster parents might feel uncomfortable with the material. As one of the child welfare workers explained:

> One of the foster parents discussing the kids in her home, her value set was very religious based many times, and I see this with a lot [of other foster families], their value sets, what they do in their own personal lives, are obviously morally grounded but the kids that they get in their homes may have a different values set and may disappoint that values set with different activities.

Application of the Training

We asked the caregivers and child welfare workers how they were applying what they had learned with youth in their care. None of the caregivers had a youth in their home at the time of their interview, but one caregiver did have a couple of youth in his home at the time he completed the training. This caregiver described how the training helped him understand the language the youth used and changed the way he communicated with them.

> At the time [of the training] we still had a couple of kids in [our home]. Picking up on some of the slang they were using I was better able to catch what they were doing, pick up on what they were doing. . .I talked to them a couple of times. Not really about anything in specific. . . . Their reaction was surprised. They were more careful about what they said around me.

Some of the caregivers who no longer had a foster youth in their home had used the training with their own children.

> I've talked with [my own] kids about lyrics. Sometimes they get it. Sometimes they're shy.

Child welfare workers reported speaking to some of the youth they work with about topics that were covered during the training, such as healthy relationships and contraception. As these two child welfares noted:

> I talked to some of my teenage clients about positive social and romantic relationships. If they need to talk to anybody about sex or where to get contraception, I shared that information with them. . . . Some positive [responses], asking where can I get contraception, is it free?

> I've also talked to a couple of my clients about healthy sexual relationships, healthy romantic relationships, and also about good touch/bad touch.

Although youth tended to respond positively to these conversations, one child welfare worker was surprised by how some reacted:

> [I also talked] about not feeling guilty about their body parts or even how they may touch themselves or not touch themselves in regards to knowing their body. . . . Some told me that "I'm not allowed to touch my privates. It's the devil." Just talking about some ideas which have been put on them or things they have learned from their parents or other people.

Several child welfare workers also reported sharing some of what they had learned with their colleagues.

> [I have used] the statistics from the training to educate my peers.

Impressions of Trainers

We asked the caregivers and child welfare workers we interviewed to give us their impressions of trainers who facilitated their training. The feedback we received was overwhelmingly positive. Several individuals commented on the trainers' ability to lead a good discussion. One caregiver appreciated the receptivity of the trainer.

> We were fortunate that we had a very receptive trainer and she definitely was open to thoughts and ideas.

Similarly, this child welfare worker like the trainers' presentation style:

> The way the trainers presented it, using real life examples. The way that the trainers presented it, I guess. It wasn't so dry, just reading the material.

One child welfare worker could not find enough superlatives to describe one of the trainers:

> The guy who did the training was great. I mean, the lady was awesome too, but the guy was very great. I can't think of his name. I've heard that he does trainings all the time. He was an excellent trainer. An excellent presenter. . . foster parents and staff would like his presentation method and go to more trainings.

Need for Additional Training or Resources

Although the training was generally regarded as thorough, some of the caregivers and child welfare workers we spoke with saw a need for additional training and resources on particular topics. One of those topics was pregnancy prevention. As one caregiver explained:

> Almost anything on pregnancy prevention would be a helpful resource. The class. . . I'm trying to think. Not that the class didn't present it. It's just that there's always different approaches to everything that you do. And some kids are just harder to reach than the others.

Communication was another topic on which additional training was requested. Caregivers and child welfare workers were interested in strategies for communicating not only with youth in care but also with foster parents.

> Letting youth know that I'm not just a child welfare worker. I am here to help them. . . . Now that I'm in administration to make sure that staff also have those conversations with the foster parents to ensure that the foster parents are having it with the kids. We want to make sure that it's not an embarrassing conversation. It's a lifesaving conversation.

Use of the Virtual Training Center (VTC)

We asked caregivers and child welfare workers about their prior and likely future use of the VTC. Several of those who had used the VTC had had trouble finding the material they were looking for. According to one child welfare worker:

> I didn't see the [materials] on the VTC. I know budget is an issue. [DCFS can] offer [handouts] online to make sure things can be available, especially if you can't take [handouts from the training] home. . .both myself and [one of the] trainers could not find the materials on the VTC.

Another child welfare worker had a similar negative experience:

> I saw them one day and then went back and they were gone. I went back because I wanted to print them out and give them to my coworkers. I have not been able to find them. I know sometimes they take stuff down or move them.

As one caregiver who did not plan on using the VTC explained,

> I will probably work more closely with a caseworker or go to trainings. I'm more of a people person.

Recommending the Training to Others

With perhaps one exception, the caregivers and child welfare workers we spoke to said that they would recommend the training to others.[13] As one child welfare worker reported:

> I already have [recommended the training]. I sent a monthly e-mail to foster parents…I mentioned that I enjoyed [this training].

Among the reasons they gave for recommending the training were the group discussions and the facilitators.

[13] The one caregiver who would not recommend the training did not provide a clear reason and, in fact, had considered repeating the training at another location.

Recommendations for Improvement

Caregivers and child welfare workers offered a number of recommendations for ways in which the training could be improved. Some of these recommendations focused on the content of the training. One suggestion was to include more information about STIs. In the opinion of this child welfare worker:

> [It] might not have been bad to go into STDs and signs and symptoms [of STDs] a little more. Maybe that's useful for caregivers. New things come out all the time.

One caregiver objected to the lack of attention to the prophylactic benefits of condoms beyond contraception:

> In the class, we always seemed to talk about condoms as pregnancy prevention. Condoms also need to be thought about as a safety prevention. We need to help people realize that heterosexuals aren't using condoms enough.

One child welfare worker thought the trainers should be able to customize the training to meet the needs of attendees:

> [Training could be improved if trainers were] allowed to tailor it to the audience. Have activities based on who's in the room. More flexibility because there are time constraints, especially for parents.

Two caregivers took issue with the way the training addressed the sexual development of LGBTQ youth. One commented:

> I thought it was lacking from the perspective of homosexual youth. Slanted toward the heterosexual child… Being a homosexual it seems like sexuality is boiled down to sexual behavior…For homosexuals life is not just boiled down to sexual behavior. We have to educate people of ages and stages of development for normal heterosexual youth are different for normal homosexual youth.

One caregiver suggested that LGBTQ issues should be a separate topic.

> Some of the topics addressed homosexuality, kind of sprinkled in here and there. I thought it might be more useful to have a whole section on homosexuality rather than throw it in here and there. Another caregiver went even further, suggesting that an entire training should be devoted to the sexual health needs of LGBTQ youth in care:

> [Promoting safe sex choice among LGTBQ youth in care] could be compartmentalized into its own training. People seem to have a hard time [with LGBTQ issues], people who don't understand the community. [I saw this] perspective from PRIDE training.

Other recommendations were less about content than about other aspects of the training. Several individuals who had difficulty accessing materials on the VTC wished that handouts to take home had been distributed. One of the caregivers suggested that training be spread over the course of three days.

> From a scheduling standpoint, our training was only two days. I think you need to add one additional day. Trying to get too much in.

Another suggested that trainings not be held on Friday.

> [What I liked least about the training was] the fact that it was on a Friday night, two Fridays in a row.

Finally, one child welfare worker thought the trainers should be equipped with laptops and projectors.

> I feel bad for the trainers. [They are] not equipped with everything they should. [Our office] brought a laptop and a projector.

Trainer Interviews

In this chapter, we summarize what we heard from the five trainers we interviewed. Although we have no reason to believe that the experiences of these trainers were vastly different from the experiences of the trainers we did not interview, the small size of our sample does limit our ability to generalize from these results.

Motivation

We asked the trainers why they had chosen (or been chosen) to facilitate a training on pregnancy prevention and healthy sexual development. One trainer reported that it was not a choice—she happened to be available. However, she acknowledged that being a native of the area where the trainings were located may also have played a role. The other four trainers cited their comfort level with or their understanding of the subject. One of these trainers described the topic as one of her "passions." Another wanted to work with her cotrainer because they had "good chemistry."

Engagement

We asked trainers about the strategies they used to engage participants in the training. Two trainers mentioned engaging participants in conversations, either about themselves or about unrelated topics. One trainer noted that being acquainted with many of the child welfare workers helped with engagement. Another called participants prior to the training to answer any questions they might have. Other engagement strategies trainers used included humor and role plays.

One trainer drew an important distinction between caregivers and some child welfare workers who were attending the training voluntarily and typically want to be there and child welfare workers who were "mandated" to attend and not interested in the training. Some of the child welfare workers who are required to attend the training write case notes or perform other tasks. This trainer tries to engage them but does not press them if they choose not to participate.

Training Caregivers and Child Welfare Workers Together

We also asked the trainers if they had encountered any problems training caregivers and child welfare workers together. Training caregivers and child welfare workers together was not perceived to be a problem by any of the trainers. On the contrary, having both groups in the room at the same time was thought to promote good dialogue. However, one trainer noted that it was important to engage members of both groups in any dialogue because they tended to have different perspectives on the issues.

Two trainers told us that there was a tendency for the caregivers and the child welfare workers to sit separately. However, this may have reflected a desire on the part of both caregivers and child welfare workers to sit with people with whom they were already acquainted. Moreover, a couple of trainers indicated that the training promoted a sense of camaraderie between caregivers and child welfare workers and that the respect the two groups had for one another grew over the course of the training. Interestingly, one trainer commented that caregivers sometimes appeared guarded or apprehensive, depending on the reception they received from the child welfare workers, but another trainer didn't think that was the case.

Overall Reactions to the Training

Trainers reported that reactions to the training had generally been positive and that participants were very candid during discussions.[14] One trainer noted that caregivers really appreciated the information that was presented because they knew they needed to talk with the youth in their care about sex. According to another trainer, some caregivers wondered why it had taken so long for DCFS to provide this type of training and wanted to know where they could get additional information about the topics that were covered.

Although none of the trainers reported receiving any negative feedback from the caregivers, two reported that some child welfare workers thought the curriculum had been "dumbed down" or was too "elementary." One of these trainers reminded the child welfare workers they were not the only ones being trained, and that, unlike the child welfare workers, most of the caregivers did not have bachelor's or master's degrees.

One trainer observed that child welfare workers were often very eager to learn on the first day of training but became bored on day two because they felt the material was redundant and they were not learning anything new. Another trainer indicated that although some of the child welfare workers found the training useful and asked for additional information, others felt they already have too much to do and they did not view the training as particularly relevant to their work.

[14] One trainer who did not have much interaction with participants after the training reported that his cofacilitator had received positive feedback.

Reactions to Activities

Trainers did not provide an overall assessment of engagement in the activities. However, one trainer observed that participation in the activities increased over the course of the training, and even became "competitive" as individuals "really got into it."

Different trainers reported different reactions to the same activities. For example, one trainer reported that sex bingo and the jargon activity sparked a lot of conversation because participants realized just how much they did not know. Another reported that participants were willing to play sex bingo but were "not thrilled about it." Similarly, one trainer reported that participants were "not wild about role plays," and caregivers were quicker to participate than child welfare workers. Another reported that the role play about gender identity produced the most discussion.

Two trainers provided feedback about the "Where Do You Stand?" activity. One noted that it forces participants to think about the way youth think and sets the stage for rest of the training. However, the other indicated that this activity sometimes caused confusion because participants thought they were supposed to express their own beliefs rather than the beliefs of a youth. The one trainer who commented on how participants responded to the music videos reported that the videos made participants think about their own upbringing and how communication has changed over time.

Controversial Topics

None of the trainer reported "pushback" from either caregivers or child welfare workers on any of the topics that might be thought of as controversial. However, one noted that some more introverted participants seemed uncomfortable with a few of the role plays. She would give them those participants the smallest part to keep them engaged but let them know that sitting out was always an option.

Modifications

None of the trainers reported modifying the training. In fact, one made a concerted effort to "stay true to the curriculum" to maintain fidelity. Four of the trainers said that participants had no problem understanding any of the information that was presented. The other noted that some older caregivers were not familiar with certain terms, such as the different types of birth control, but did not think this required changing the curriculum. This same trainer did report changing some of the slang terms that are used when the training was located in a rural area.

Recommendations

Trainers offered a number of recommendations for improving the training.

- One trainer, who had only had two planning calls with his cofacilitator, suggested having more preparation time.

- Although all the trainers agreed that caregivers and child welfare workers should continue to be trained together, one suggested that participants be made aware ahead of time that both groups will be present. Another recommended that child welfare workers should only attend if they really want to be there; otherwise their presence becomes a distraction.
- Two trainers recommended that some of the activities, and especially some of the role plays, be eliminated to allow more time for discussion.
- Another trainer suggested that a third day be added because there are so many activities to complete.
- Trainers recommended that more handouts and additional information about birth control be made available to participants.

Discussion and Implications

Summary of Findings

We begin our discussion with a summary of our major findings.

Survey Data

- The percentage of caregivers and child welfare workers who responded correctly to the questions about sexual health or development changed very little over time, and few differences were found either pre- or posttraining between caregivers and child welfare workers.
- There was widespread agreement among both caregivers and child welfare workers about the need to talk with youth in care about sexual health. Where differences were found, child welfare workers were more likely than caregivers to express support for talking about sexual health with youth in care, and those differences were larger before than after the training.
- Caregivers and child welfare workers were most likely to have talked with a youth in care about healthy relationships, sexual abuse, or puberty and least likely to have talked with a youth in care about masturbation or gender identity. Where differences were found, child welfare workers were more likely than caregivers to have talked about those topics with a youth in care.
- Although there was relatively little change in how comfortable caregivers and child welfare workers would feel talking about various sexual health-related topics with youth in care over time, the changes that were observed were in the direction of increased comfort levels. Prior to the training, child welfare workers reported feeling more comfortable than caregivers talking about sexual health related topics with youth in care. After the training, those differences had largely disappeared.
- Views of the training and the trainers were generally positive, although caregivers tended to rate both the training and the trainers more highly than child welfare workers. Most caregivers and child welfare workers reported learning as much as, if not more than, they had expected from the training, and the vast majority of both groups would recommend it to others.

- Both groups reported learning a moderate amount from the activities, but caregivers generally reported learning more than child welfare workers.
- Only one in five caregivers or child welfare workers reported that attending the training with both caregivers and child welfare workers caused any discomfort.

Interview Data

- Both caregivers and child welfare workers agreed that this type of training was badly needed. However, child welfare workers tended to focus on training needs of foster parents rather than on their own training needs.
- Although the training was not what caregivers and child welfare workers had been expecting, they were generally satisfied with the experience. Members of both groups appreciated the information that was presented on healthy sexual development and expressed surprise about the high rate of pregnancy and STIs among youth in care. Trainers agreed that reactions to the training had generally been positive but a couple reported complaints from some child welfare workers that the curriculum had been "dumbed down."
- Self-reported reactions to the activities by caregivers and child welfare workers were largely, but not exclusively, positive. Trainers reported a more mixed response, perhaps because the caregivers and child welfare workers we interviewed were a self-selected group.
- Although the child welfare workers did not perceive a conflict between the training and their personal values, several could imagine how the material might cause discomfort for some foster parents. However, none of the trainers reported "pushback" on any of the potentially controversial topics from either caregivers or child welfare workers.
- Child welfare workers reported speaking to youth in care about some of the topics that were covered and sharing some of what they had learned with their colleagues. Although they did not currently have any youth in their care, some caregivers were applying what they had learned from the training with their biological children.
- Feedback about the trainers was overwhelmingly positive. Caregivers and child welfare workers were impressed by their ability to lead a discussion and their presentation style.
- Without exception, training caregivers and child welfare workers together was perceived as beneficial. Caregivers and child welfare workers saw the joint trainings as an opportunity to learn about the respective challenges they faced and to better understand their respective roles in educating youth in care about pregnancy prevention, healthy relationships and sexual health. Trainers thought having both groups in the same room promoted good dialogue.

Discussion

What was clear from both the qualitative (interview) and quantitative (survey) data is that there is a pressing need for this type of training among both caregivers and child welfare workers. Although both groups seem to recognize the imperative of talking with youth in care about sexual health and pregnancy prevention, those conversations often don't take place. Our data suggest that this failure may be due at least as much to a lack of comfort discussing particular issues as to a lack of knowledge. Hence, improving the ability of caregivers and child welfare workers to communicate effectively with youth in care is as essential as providing them with factual information.

It is worth noting that although both caregivers and child welfare workers stand to benefit from this type of training, child welfare workers' comments about why this training is needed focused on foster parents. This could reflect the fact that child welfare workers perceive themselves as already doing much of what the training aims to promote. Child welfare workers were more likely than caregivers to report having had discussions with youth in care about sexual health and pregnancy prevention. They also reported feeling more comfortable about having those discussions. (Of course, those differences had largely disappeared by the end of the training.) It could also reflect the fact that child welfare workers are charged not only with talking directly with youth in care about sexual health and pregnancy prevention but also with encouraging caregivers to do the same.

We did not observe much increase in caregiver or child welfare worker knowledge of healthy sexual development or the high rate of pregnancy among youth in care at the aggregate level. However, this was largely due to the higher than expected percentage of caregivers and child welfare workers who responded correctly to the knowledge items on the pretraining survey. It is possible that more change would have been observed had the surveys included more or different items. More importantly, despite what might, at first glance, appear to be disappointing results, the interview data suggest that most caregivers and child welfare learned quite a bit, not only from the information that was presented but also as a result of their participation in the activities.

Our survey data indicate that, on average, caregivers and child welfare workers learned a moderate amount from each of the activities in which they took part. However, the interviews we conducted with caregivers, child welfare workers, and trainers suggest that those averages may have obscured more extreme positive and negative responses. In some cases, reactions to the same activity ranged from very positive to much more negative. Among the activities that elicited the most feedback were the New Jargon activity and the music lyrics and videos activity. Both of these activities draw attention to the language used by youth and why understanding that language is important if caregivers and child welfare workers are to communicate effectively with youth in care.

The Department took a risk when it decided to train caregivers and child welfare workers together on what is arguably a sensitive topic. However, both the quantitative and qualitative data we collected support the Department's decision. Most of the caregivers and child welfare workers who completed the survey would not have felt more comfortable if the training had only been attended by other caregivers or other child welfare workers. Moreover, none of the caregivers, child welfare workers, or trainers we interviewed thought that training caregivers and child welfare workers together was a mistake. On the contrary, they all agreed that each group benefited from the presence of the other.

Recommendations

Based on the quantitative and qualitative data we collected, we have several recommendations for moving forward if the Department decides to continue offering this training or something similar after the interagency agreement with the Illinois Department of Human Services (DHS) expires. Some of these recommendations concern the implementation of the training and could be addressed by the Office of Training and Professional Development. Others deal more with future research.

Training Implementation

- *Engage in more targeted recruitment efforts.* The high percentage of correct responses to the knowledge items on the pretraining survey suggests that the caregivers and child welfare workers who completed the training may have been a self-selected group who were already at least somewhat familiar with the information that was presented. Recruiting caregivers and child welfare workers who lack even that basic knowledge and who may not take the initiative to register for the training is likely to require more targeted outreach.
- *Ensure that the training materials are available on the VTC.* Our survey data suggested not only that most caregivers and child welfare workers knew how to access information through the VTC but also that many had already done so. However, a number of the caregivers and child welfare workers we interviewed reported problems finding the materials they were looking for on the VTC.
- *Provide additional training and resources on select topics.* Despite being generally satisfied with their training experience, caregivers and child welfare workers did request additional resources and training on a number of specific topics. These included pregnancy prevention, communicating with youth in care as well as foster parents, and the needs of youth in care who identify as LGBTQ.
- *Continue training caregivers and child welfare workers together but with some minor changes.* Although caregivers, child welfare workers, and trainers all agreed that training caregivers and child welfare workers together is a good idea, it is not clear from the description of the training on the VTC that caregivers and child welfare workers will attend the same sessions. Caregivers and child welfare workers should be made aware of this ahead of time.

Future Research

- *Observation of the training sessions.* Budget constraints precluded us from observing the training sessions. Future implementation studies should include an observation component. This would allow a more systematic examination of how trainers interact with both caregivers and child welfare worker and how caregivers and child welfare
- *Focus groups with youth in care.* Although we know something about how caregivers and child welfare workers were applying what they had learned from the training, it is important to find out if the training made a difference from the perspective of youth in their care. One approach would be to conduct two sets of focus groups: one with youth whose caregivers and child welfare workers had been trained and another with youth whose caregivers and child welfare workers had not.
- *Impact evaluation.* Ultimately the purpose of this training is to prevent youth in care from becoming pregnant and encourage them to make healthy decisions about their sexual behaviors and relationships. Evaluating the impact of the training would require a long-term study that compares the outcomes of youth in care whose caregivers and child welfare workers had been trained to the outcomes of youth in care whose caregivers and child welfare workers had not. Ideally, the evaluation would use an experimental design with random assignment or a quasi-experimental design with a carefully chosen comparison group.

Appendix A

Table A-1. Characteristics of Pre-Training Survey Respondents by DCFS Region

Characteristic	Central (*n* = 74)	Northern/Cook (*n* = 120)	Southern (*n* = 34)
	%	%	%
Relationship to DCFS			
Caregiver only	28.4	58.3	82.4
Child welfare worker only	63.5	37.5	14.7
Both	8.1	4.2	2.9
Gender			
Female	78.4	79.2	70.6
Male	21.6	20.0	26.5
Missing data	0.0	0.8	2.9
Race			
White	73.0	41.7	70.6
Black	23.0	45.0	17.7
Hispanic	1.4	6.7	0.0
Other	0.0	0.0	5.8
Multiracial	2.7	5.0	2.9
Missing data	0.0	1.7	2.9
Age			
Under 30 years old	13.5	8.3	8.8
30 to 39 years old	24.3	25.0	17.7
40 to 49 years old	23.0	22.5	14.7
50 to 59 years old	25.7	19.2	32.4
At least 60 years	12.2	17.5	14.7
Missing data	1.4	7.5	11.8
Mean	44.1	45.3	48.6
Education			
No high school diploma or GED	1.4	8.3	5.9
High school diploma or GED	6.8	21.7	47.1
2 year college degree	10.8	16.7	14.7
4 year college degree	39.2	28.3	11.8
Advanced degree	40.5	24.2	17.7
Missing data	1.4	0.8	2.9

Table A-2. Pretraining Knowledge about Healthy Sexual Development by DCFS Region[a]

Item	Central (*n* = 74)	Northern/Cook (*n* = 120)	Southern (*n* = 34)
Sexual development begins around the time children enter puberty. (F)			
True (%)	30.2	38.4	44.1
False (%)	69.8	61.6	55.9
Missing data (*n*)	11	8	34
Youth in care have a right to receive family planning services beginning at age 12. (T)			
True (%)	88.9	85.8	87.5
False (%)	11.1	14.2	12.5
Missing data (*n*)	11	7	2
Youth in care are no more likely to become pregnant than other adolescents. (F)			
True (%)	33.3	29.2	48.5
False (%)	66.7	70.8	51.5
Missing data (*n*)	8	7	1
All contraceptives protect against STIs as well as pregnancy. (F)			
True (%)	3.0	3.5	2.9
False (%)	97.0	96.5	97.1
Missing data (*n*)	7	6	34
Childhood trauma can affect the decisions youth in care make about relationships. (T)			
True (%)	100.0	98.2	97.1
False (%)	0.0	1.8	2.9
Missing data (*n*)	7	9	34

[a] The "T" or "F" in parenthesis indicates the correct answer.

Table A-3. Posttraining Knowledge About Healthy Sexual Development by DCFS Region

Item	Central (*n* = 95)	Northern/Cook (*n* = 100)	Southern (*n* = 23)
	%	%	%
Sexual development begins around the time children enter puberty. (F)			
True (%)	19.4	43.5	44.4
False (%)	80.7	56.5	55.6
Missing data (*n)*	2	15	5
Youth in care have a right to receive family planning services beginning at age 12. (T)			
True (%)	96.8	87.8	86.4
False (%)	3.2	12.2	13.6
Missing data (*n*)	2	2	1
Youth in care are no more likely to become pregnant than other adolescents. (F)			
True (%)	27.7	44.0	39.1
False (%)	72.3	56.0	60.9
Missing data (*n*)	1	0	0
All contraceptives protect against STIs as well as pregnancy. (F)			
True (%)	0.0	9.2	4.6
False (%)	100.0	90.8	95.5
Missing data (*n*)	3	2	1
Childhood trauma can affect the decisions youth in care make about relationships. (T)			
True (%)	100.0	87.0	82.6
False (%)	0.0	13.0	17.4
Missing data (*n*)	2	0	0

Table A-4. Pretraining Responses to Questions Related to Talking about Sexual Health by DCFS Region

Item	Central (*n* = 74)	Northern/Cook (*n* = 120)	Southern (*n* = 34)
I should only discuss sexual health with youth in care if they initiate the conversation.			
Agree or strongly agree (%)	12.5	13.1	18.8
Disagree or strongly disagree (%)	87.5	86.9	81.3
Missing data (*n*)	2	13	2
I only need to have "the talk" once with each youth in care.			
Agree or strongly agree (%)	0.0	4.7	3.2
Disagree or strongly disagree (%)	100.0	95.3	96.8
Missing data (*n*)	4	13	3
It is better to ignore some questions about sexual health because children are too young to understand the answers.			
Agree or strongly agree (%)	2.7	11.2	9.4
Disagree or strongly disagree (%)	97.3	88.8	90.6
Missing data (*n*)	1	13	2
Youth in care learn all they need to know about sexual health from sex education classes in school.			
Agree or strongly agree (%)	4.2	6.5	6.1
Disagree or strongly disagree (%)	95.8	93.5	93.9
Missing data (*n*)	3	12	1
Talking with youth about sex only sends the message that it is okay for them to be having sex.			
Agree or strongly agree (%)	0.0	4.7	0.0
Disagree or strongly disagree (%)	100.0	95.3	100.0
Missing data (*n*)	4	13	1
I could put my personal values aside when talking with youth about sex health.			
Agree or strongly agree (%)	75.8	78.7	74.2
Disagree or strongly disagree (%)	24.2	21.3	25.8
Missing data (*n*)	8	12	3
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.			
Agree or strongly agree (%)	87.1	89.9	93.6
Disagree or strongly disagree (%)	12.9	10.1	6.5
Missing data (*n*)	4	11	3

Table A-5. Posttraining Responses to Questions Related to Talking about Sexual Health by DCFS Region

Item	Central (*n* = 95)	Northern/Cook (*n* = 100)	Southern (*n* = 23)
I should only discuss sexual health with youth in care if they initiate the conversation.			
Agree or strongly agree (%)	5.3	13.1	4.6
Disagree or strongly disagree (%)	94.7	86.9	95.5
Missing data (*n*)	1	1	1
I only need to have "the talk" once with each youth in care.			
Agree or strongly agree (%)	2.2	5.1	4.4
Disagree or strongly disagree (%)	97.9	95.0	95.7
Missing data (*n*)	2	1	0
It is better to ignore some questions about sexual health because children are too young to understand the answers.			
Agree or strongly agree (%)	2.1	6.0	9.1
Disagree or strongly disagree (%)	97.9	94.0	90.9
Missing data (*n*)	1	0	1
Youth in care learn all they need to know about sexual health from sex education classes in school.			
Agree or strongly agree (%)	1.1	5.1	0.0
Disagree or strongly disagree (%)	98.9	95.0	100.0
Missing data (*n*)	1	1	0
Talking with youth about sex only sends the message that it is okay for them to be having sex.			
Agree or strongly agree (%)	2.2	7.1	8.7
Disagree or strongly disagree (%)	97.8	92.9	91.3
Missing data (*n*)	3	2	0
I could put my personal values aside when talking with youth about sex health.			
Agree or strongly agree (%)	82.6	83.8	91.3
Disagree or strongly disagree (%)	17.4	16.2	8.7
Missing data (*n*)	3	1	0
I would know where to turn for information about sexual health if a youth asked me a question I could not answer.			
Agree or strongly agree (%)	91.0	87.2	93.8
Disagree or strongly disagree (%)	9.0	12.8	6.3
Missing data (*n*)	17	14	7

Table A-6. Pretraining and Posttraining Beliefs about Experimentation with Sexual Orientation

Item	Central	Northern/Cook	Southern
It is healthy for youth to question or experiment with their sexual orientation			
Pretraining	*n* = 64	*n* = 108	*n* = 31
Agree or strongly agree (%)	84.4	82.4	71
Disagree or strongly disagree (%)	15.6	17.6	29
Missing data (*n*)	10	12	3
Posttraining	*n* = 92	*n* = 99	*n* = 23
Agree or strongly agree (%)	77.2	77.8	56.5
Disagree or strongly disagree (%)	22.8	22.2	43.5
Missing data (*n*)	3	1	0

Table A-7. Ever Talked with Youth in Care about Sexual Health Topics by DCFS Region

Topic	Central (*n* = 74)	Northern/Cook (*n* = 120)	Southern (*n* = 34)
Puberty and physical changes			
Yes (%)	71.4	80.4	51.6
No (%)	28.6	19.6	48.4
Missing data (*n*)	11	113	3
Healthy romantic and sexual relationships			
Yes (%)	78.8	73.9	54.8
No (%)	21.2	26.1	45.2
Missing data (*n*)	8	9	3
Masturbation			
Yes (%)	51.6	41.5	25.0
No (%)	48.4	58.5	75.0
Missing data (*n*)	10	14	2
Sexual orientation			
Yes (%)	71.0	69.1	43.8
No (%)	29.0	30.9	56.3
Missing data (*n*)	12	10	2
Gender identity			
Yes (%)	54.7	50.0	32.3
No (%)	45.3	50.0	67.7
Missing data (*n*)	10	12	3
Contraception/birth control			
Yes (%)	75.0	70.8	53.1
No (%)	25.0	29.3	46.9
Missing data (*n*)	10	14	2
STI or HIV/AIDS prevention			
Yes (%)	75.8	71.3	46.9
No (%)	24.2	28.7	53.1
Missing data (*n*)	12	12	2
Peer pressure to engage in sexual behavior			
Yes (%)	68.8	72.9	58.1
No (%)	31.3	27.1	41.9
Missing data (*n*)	10	13	3
Sexual content in popular culture			
Yes (%)	65.0	72.9	51.6
No (%)	35.0	27.1	48.4
Missing data (*n*)	14	13	3
Sexual abuse			
Yes (%)	74.2	75.0	65.6
No (%)	25.8	25.0	34.4
Missing data (*n*)	8	12	2
Pregnancy and child birth			
Yes (%)	79.0	73.1	50.0
No (%)	21.0	26.9	50.0
Missing data (*n*)	12	16	4

Table A-8. Pretraining Comfort Level with Talking about Sexual Health Topics by DCFS Region

Topic	Central			Northern/Cook			Southern		
	n	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Puberty and physical changes	70	3.7	0.50	111	3.6	0.64	34	3.4	0.78
Healthy romantic and sexual relationships	69	3.8	0.44	111	3.6	0.63	34	3.6	0.74
Masturbation	69	3.1	0.94	109	2.9	1.08	34	2.5	1.08
Sexual orientation or gender identity	68	3.6	0.58	111	3.4	0.81	34	3.1	0.86
Gender identity	68	3.6	0.57	105	3.4	0.87	33	3.2	0.85
Contraception/birth control	68	3.8	0.37	111	3.7	0.61	34	3.6	0.78
STI or HIV/AIDS prevention	68	3.8	0.42	110	3.7	0.60	34	3.7	0.59
Peer pressure to engage in sexual behavior	67	3.9	0.36	108	3.8	0.47	34	3.6	0.66
Sexual content in popular culture	67	3.8	0.39	109	3.7	0.50	34	3.6	0.60
Sexual abuse	69	3.7	0.50	111	3.6	0.62	33	3.5	0.71
Pregnancy and child birth	68	3.7	0.78	112	3.7	0.65	34	3.6	0.65

Table A-9. Posttraining Comfort Level with Talking about Sexual Health Topics by DCFS Region

Topic	Central			Northern/Cook			Southern		
	n	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Puberty and physical changes	93	3.7	0.51	96	3.3	0.99	23	2.9	1.12
Healthy romantic and sexual relationships	92	3.8	0.39	98	3.7	0.62	23	3.5	0.73
Masturbation	91	3.2	0.82	98	3.2	0.90	23	3.0	0.93
Sexual orientation or gender identity	94	3.6	0.60	99	3.5	0.77	21	3.0	0.95
Gender identity	90	3.4	0.67	97	3.5	0.72	23	3.2	0.72
Contraception/birth control	91	3.8	0.38	99	3.7	0.58	22	3.5	0.80
STI or HIV/AIDS prevention	91	3.8	0.38	98	3.7	0.61	23	3.7	0.70
Peer pressure to engage in sexual behavior	94	3.8	0.37	97	3.8	0.54	23	3.7	0.71
Sexual content in popular culture	92	3.8	0.36	96	3.7	0.57	22	3.6	0.73
Sexual abuse	92	3.7	0.52	98	3.6	0.75	23	3.5	0.79
Pregnancy and child birth	92	3.8	0.41	98	3.6	0.73	23	3.6	0.73

Table A-10. Ratings of Trainers by DCFS Region

Item	Central			Northern/Cook			Southern		
	n	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Trainers know a lot about the subject.	77	3.5	0.50	70	3.6	0.61	22	3.5	0.51
Trainers presented the material clearly.	75	3.5	0.50	71	3.7	0.54	22	3.5	0.51
I plan to use what I learned from this training.	76	3.4	0.56	71	3.6	0.59	21	3.6	0.50
I learned a lot from this training.	76	3.0	0.74	68	3.5	0.66	22	3.3	0.48
Trainers did a good job of answering questions.	77	3.5	0.50	70	3.7	0.55	22	3.5	0.51
I would attend future trainings on this subject.	77	3.2	0.82	69	3.6	0.61	21	3.4	0.59
I felt comfortable sharing my opinions	78	3.5	0.50	70	3.6	0.67	22	3.6	0.50
Trainers respected what I had to say.	77	3.6	0.50	70	3.6	0.62	22	3.6	0.50
Training made me think about personal values.	77	3.3	0.64	70	3.5	0.63	22	3.4	0.49

Table A-11. Opinions about Training by DCFS Region

Item	Central (*n* = 95)	Northern/Cook (*n* = 100)	Southern (*n* = 23)
Training taught me…			
Less than expected (%)	13.0	1.5	0.0
As much as expected (%)	62.3	33.3	40.9
More than expected (%)	24.7	65.2	59.1
Missing data (*n*)	18	31	1
Training was…			
Too short (%)	64.9	66.2	91.3
Right length (%)	13.0	17.7	0.0
Too long (%)	22.1	16.2	8.7
Missing data (*n*)	18	32	0
Training was…			
Too basic (%)	28.6	10.1	13.0
Right level (%)	71.4	88.4	87.0
Too advanced (%)	0.0	1.5	0.0
Missing data (*n*)	18	31	0

Table A-12. Ratings of Activities by DCFS Region

Activity	Central			Northern/Cook			Southern		
	n	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Day One Activities									
Crucial Connection video	56	3.2	0.86	66	3.4	0.66	21	3.2	0.70
Agree/disagree	64	2.8	1.05	70	3.3	0.71	23	3.3	0.75
True/false quiz	72	3.0	0.83	67	3.4	0.75	23	3.4	0.66
Sex Bingo	60	2.8	0.97	70	3.4	0.82	22	3.2	0.81
Where Do You Stand? sexuality opinion survey	67	3.0	0.92	63	3.3	0.82	23	3.2	0.74
Under Your Hat	63	3.2	0.82	67	3.4	0.72	21	3.4	0.60
New Jargon activity	70	3.5	0.85	64	3.5	0.71	19	3.5	0.70
Homework	56	2.8	0.99	67	3.1	0.90	18	3.0	0.84
Day Two Activities									
True/false quiz	75	2.8	0.94	70	3.2	0.85	23	3.1	0.81
Create a Definition for Youth of Healthy Sexuality	77	3.0	0.99	66	3.4	0.69	23	3.0	0.85
What Is Love?: Youth perceptions	75	3.2	0.87	69	3.4	0.73	22	3.2	0.59
Love, Lust, or Rebounding?	72	3.1	0.90	70	3.4	0.75	23	3.1	0.69
Role playing exercise	74	2.8	1.01	65	3.4	0.80	14	2.9	0.86
Naming contraceptives	74	2.8	1.02	59	3.3	0.81	20	2.9	0.91
Window of Opportunity activity	70	3.1	0.89	62	3.4	0.67	20	3.5	0.60

Table A-13. Caregiver Recommendations by DCFS Region

Item	Central (*n* = 49)	Northern/Cook (*n* = 65)	Southern (*n* = 18)
Would recommend training to other caregivers.			
Disagree or strongly disagree (%)	8.3	3.0	5.6
Agree or strongly agree (%)	91.7	96.2	94.4
Missing data(*n*)	1	13	0
Would have felt more comfortable if training were only open to caregivers.			
Disagree or strongly disagree (%)	81.4	83.0	85.6
Agree or strongly agree (%)	18.6	17.0	14.3
Missing data (*n*)	6	18	4

Table A-14. Child Welfare Worker Recommendations by DCFS Region

Item	Central (*n* = 54)	Northern/Cook (*n* = 36)	Southern (*n* = 8)
Would recommend training to other child welfare workers.			
Disagree or strongly disagree (%)	10.3	0.0	12.5
Agree or strongly agree (%)	89.7	100.0	87.5
Missing data (*n*)	15	12	0
Would have felt more comfortable if training were only open to child welfare workers.			
Disagree or strongly disagree (%)	80.0	75.0	87.5
Agree or strongly agree (%)	20.0	25.0	12.5
Missing data (*n*)	14	12	0

Table A-15. Knowledge and Use of VTC by DCFS Region

	Central (*n* = 95)	Northern/Cook (*n* = 100)	Southern (*n* = 23)
Know how to access information through the VTC			
Disagree or strongly disagree (%)	6.6	13.2	8.7
Agree or strongly agree (%)	93.4	86.8	91.3
Missing data (*n*)	19	32	0
Know what information I can access through the VTC			
Disagree or strongly disagree (%)	9.1	13.2	9.1
Agree or strongly agree (%)	90.9	86.8	90.9
Missing data (*n*)	18	32	1
Plan to access information through the VTC in the future			
Disagree or strongly disagree (%)	6.9	12.1	9.1
Agree or strongly agree (%)	93.2	87.9	90.9
Missing data (*n*)	22	34	1
Have already accessed resources through the VTC			
No (%)	32.5	40.3	28.6
Yes (%)	67.5	59.7	71.4
Missing data (*n*)	18	33	2
Have accessed VTC resources with a youth in care			
No (%)	56.9	67.2	38.1
Yes (%)	43.1	32.8	61.9
Missing data (*n*)	23	39	2