Promoting What Works
A Symposium of Promising Approaches for Supporting
Pregnant and Parenting Adolescents

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Emerging and Promising Approaches: What does implementation really look like?

Reesa Webb: We are happily back on schedule. You'll recall this morning we started the morning talking about the research that's being done. We then had a panel talking about some of the promising practices and programs going on Pat just enlightened us about Policy happening at the national level. We are at the state where we are going to visit the what I call . rubber hits the road. and that's the implementation. We have another panel that I would like to invite up here now. We have Dr. Marc Clark who is going to moderate the panel. Dr. Clark is the Director of the Division of Teen Pregnancy Prevention Programs at the Administration for Children, Youth and Families at the Family Services Bureau. He's a school and community educator and he's directed many federally funded projects that deal with both data collection and evaluation. So please welcome Dr. Clark. He will introduce the panelists.

Dr. Marc Clark: Good afternoon. I am pleased to be part of today's gathering. I think we should recognize Alicia. Very well done. Emerging and promising approaches. I am pleased to be a part of this panel in particular. My background in HIV prevention is a first cousin to teen pregnancy prevention. I was interested in one of the participants who had a cast on; I said you know this pregnancy crowd is pretty tough. I'm glad to be welcomed here. At any rate, the clock was ticking early in the morning, so I will stay on task. Successful implementation of key program components is pivotal in determining program effectiveness. This session will present implementation strategies and discuss various approaches for adolescent pregnancy and parenting programming in diverse populations and settings. Presenters will discuss common challenges and solutions. I will introduce each panelist. For questions and answers please go to the microphone. Keep your questions short one to two minutes. Those of you participating on the webcast can type in your questions in the chat box on the screen and we will do our best to incorporate them during the answer and question session. Now for brief introductions.

Bernadette Strode. She's worked at the elementary and high school and college levels both as a teacher and administrator. Joanne Cox is an Associate Chief of General Pediatrics and Director of Children's Hospital Primary Care Center at Children's Hospital in Boston. She's also Medical Director of the Young Parents Program and which provides quality medical care and health education and teen parents and their children in low income and at risk environments. Melissa Maguire is the Director of the Youth Shelter Network at the Night Ministry and she has over 20 years' experience working with youth and homeless service agencies. Pam Plummer is the Project Director for the Centers for Youth and Families, an organization serving children and adolescents and families in

Arkansas. She's been in the Office of Adolescent Family programs as a grantee for nearly ten years. And finally Keneca Boyce is the Senior Director of Program Development and Quality Assurance at Inwood House, a teen prevention program in the Bronx Burrough of New York. She facilitates the design, implementation and Evaluation of new program initiatives for pregnant and parenting teen families currently in the runaway programs and foster care systems. We will start with Bernadette.

Bernadette Strode: Good afternoon. How are you? How is everyone this afternoon? The challenge of this afternoon is not really to convey to you what I really want but to keep you awake after you just had lunch. Work with me I am going to try my best. If you could tell me where do I go next? Okay. Okay. So I thank you for that introduction. Yes, I am Bernadette Strode Principal of Polly McCabe School in New Haven, CT. Our task there has been to provide an opportunity and appropriate education for our girls to help them to learn, and to help them to develop into moms and to help them to be productive citizens. Now, you may see something up here but my heart and my spirit once I got here today told me I am going the share the real deal with you. I am not going to tell you what researchers have said. I am going to take some of what they said and tell you actually what is going on. I noticed most of the research out there today was given I think average age was about 15-18. I am going to tell you it's very different when you are sitting across from a 12 year old and I have 12 year olds. So what we take and what we do is different from a 12 year old versus an 18 year old. So we individualize our programs. We individualize all of the things that we need to get out to them, but first and foremost what we do is embrace them and let them know that they are somebody.

Applause.

Coming in, I don't care if you are 12 or 18, coming in; our expectation is you are going to walk out of our door. You are going to be equipped with everything that you know to help you to keep learning, to know more, to keep learning, to know more, to be the best mom you can be. See they come into me at various times. I get them all year. I got one last Friday so it doesn't matter when they come in. I get them at one month pregnant. I get them at eight months pregnant. It depends. In New Haven. It says you don't have to go into an alternative program. You can stay in your high school. I average about 130-150 a year with about two hundred still in the high schools out there. So my superintendent said to me we have to rename your school you no are longer a high school, you are right. We are no longer the hidden secret we thought you were. Why I say that is you know legislation and other people sometimes they just don't want to talk about it. We talk about it. We deal with it. We face it. We let them know you are students can face it you are going to do it. We are going to help you can walk with you and you are going to be fine. So having said that. When I talked to a 12 year old who is real difficult? How do you talk to a 12 year old about being a mom? I have a 12 year old I wish she was with me today. She is teaching her mom about being a mom. They can do it. The support that they need is what we give them. That comes in many facets. Let me go through that one. The support as I said they need come in many facets. I have case managers. I have psychologists. I have social workers. I have different folks from Yale University that have been with us for 25 plus years that have a stake in our school. So it's not, we are

going to come in here each year into this. It's what do you need? What we need we have to look at? We have to, we do it. We have to revise it based on the population that we have. So when the girls come we make a plan. They are given a mentor. Now, they have three days in which to go and introduce themselves to the mentor. Why not the mentor goes introduce themselves to them? I want them to feel comfortable. I want them to feel embracement. I want them to want to have mentor. Each teacher in our school is mentor. After they meet their mentor they are assigned a case manager. I can't tell you I can't talk enough about case managers or my staff they are awesome. They are there because they want to be there. It's not there because the city placed them there. I have gotten rid of some. You want to be there. You want to make a difference. You want to know that these girls can be somebody and you are willing to do what you can to ensure that. If you are not willing Bernadette Strode is not the person you want to work. So, we take each girl individually and we look at what they need. We look at what they want. Some come in there and say I don't know. My 12 year old, one of my four 12 year olds said to me when I said to her I said where's the baby's father? What's his name? Boo. Boo who? Where does boo live? In the Tray. That's an area in New Haven. What school does Boo go to? He doesn't. He's incarcerated. Have you ever met Boo's mom and dad?

Nope. What's Boo's last name? I don't know. So we looked at the fact that they didn't have a real relationship. She got caught up with something whether it was a first night whether it was the second day or whatever. And then we had to work her through that. We had to help her deal with that. We had to help her deal with actually Boo incarcerated probably was not going to be around to help her. You know Boo there are many Boo's. I have a Boo that's 29 years old the father of a 12 year old baby. So there are many when I stand up and say there are many different stories, different situations I can't fit it in that little research box. I have to step out of that box and I have to do, we have to do what we need to do. I love those two up there that Pat just showed because I was missing my girls today. Because I'm passionate just like my staff. So when I tell you about our programs and our measurement I can only tell you what some of the outcomes are. We don't, we look at it and we don't look at it. We look at the success. The public school looks at their scores. Now imagine you being a math teacher and you are trying to teach someone algebra and they had a fight last night with their baby's father or they don't know who the baby's father is or the mother put them out and I'm 12 and I'm scared and I'm lost. There's so much work that we have to do to ensure that they get both the safety and that math because they need both. By helping them to see that and helping them to understand that is something in itself. We take a lot of time when they come to us to help them to learn and to know you can trust somebody. There are people out there that you can trust. You are not just a number. You are somebody. You are going to be a great parent one day. So as we do that there are many bumps or lumps along the way, but we make it. We make it happen. One of the things that when they come to me I tell them you're pregnant you are not sick so you are expected in school. If you get school we have a room for you to go to. I understand there's morning sickness, but you are expected to be here to give us all that you can because we are going to give you all that you can. That we can. So attendance was a big problem when I first got there. Now, they come to school because we found something that they want. They not only feel safe there, but now on Fridays we have a drawing, so if you have been in school all week long you get a ticket and if you have

been caught doing something exceptional you get a ticket. We have big ticket items that we give out on Friday's. So you don't think that they are not going to be there. Monday through Friday because you might get that stroller that you would not get, you might get that baby monitor that you wouldn't normally get. So we had to find something catchy. So that works that's working. So now that we get them there and also we are going to give you door to door service. You got door to door service. You have a place to come if I am not feeling good I can go and lie down, talk to somebody if I need too and so now okay I can do this. Guess what? I have a staff they know that they have a staff that will tell them of their high expectations. I tell them I expect no less than college. Don't come talking to me because I don't expect it. Don't give me woe is me we don't live on excuses and you are going to do this. Well, Ms. Strode why? And here's the best one and they look at me and when I say this. Because I did it. I am standing before you as your principal. I am standing before you to show you my child who I changed my life for who just, but graduated from Stanford University and went on to be a mom herself after she got married, but you are standing in front of a single mom. I did it. Well you weren't in high school. But I was the first year college, but I did it. I was a single mom so you can do it. So this is our population and that means nothing to me. These are the grade levels that we have in school. That means nothing to me because we are going to work with them all. And I think what makes us different in that my staff put up there I don't think it makes us that different because we do what we need to do. All of this that's before you is what we thought you wanted to hear, but I am going to tell you the real deal. This is it. If you give all of you to students and you expect them to achieve they will achieve if you help them. And help comes with in. You have to be someone that can listen that's all they want. They want you to hear it's hard, she told you -- Uniqwa told you how hard it was. We don't want her to stay here feeling it's hard. We have people that will take her through the process of sharing all of the information and all of the programs out there, my case manager’s work with them. They make sure they go to their doctor’s appointment. You know why they make sure is because they take them. After they give birth. I won't get into that. They make sure that they come to school you missed the bus they pick them up. I have had my truancy people because they love to say well, the bus didn't come, that's okay we are on our way. So I think I went over my time just a little bit. I hear that. I don't know if it's really what you wanted to hear, but from me this is what works for us. I can stand up here and talk to you all day because I am very passionate about what I do. Thank you.

Our next presenter is Joanne Cox.

Joanne Cox: Good afternoon. I think I am going to be a little bit more cut and dry. The passion is there but you might not hear it as much. I got to get to my talk. So the young parents program at Children's Hospital Boston goes back to 1980. I can, it is before my time but not a whole lot. I think in talking about implementation if that layering on of time learning from past mistakes and moving forward that's a big part of what we do. What I am going to describe is how we kind of put our program together currently using the medical home. This is our third project that we have had funded through the Office of Adolescent Pregnancy Programs. And it did build our needs assessments and needs assessment and we had our focus groups ans learned from the past. The other is that

everything we do has, is relate today trying to develop relationships between the teens and the staff members. And the medical home. So we use the medical home model to provide care to the adolescents, parents and their children. Through the teen tot clinic medical and social care is integrated with services to the community. Families get assigned when they come in to both a social worker and a medical provider that might be a doctor or that might be a nurse practitioner. That makes us unique because it's a very intensive social work model. And the clinic is embedded within a large pediatric practice which provides additional support with a wide range of hours. So teens can access our services across the week evenings and weekend and barriers such as transportation or resource needs are addressed also because we have a strong social work system. Just walking through this is a model and it kind of I think describes what a medical home is which is it’s the home we trying to layer on all the services and support that we have found to be useful and the literature tells us is useful. In the center we have the young parents program that provides a medical care the social services and mental health and parenting education and youth development. Teens can come to clinic for almost any need whether the baby has a fever or homeless today. Then it all starts of course with prenatal care which is delivered by the Bergerman Women's Hospital which is physically connected to Children's Hospital, in a specialized team prenatal program. We have joint meetings. Healthy Babies Healthy Child is a nurse home visiting program. Funded by the Massachusetts Department of Public Health. It starts in the prenatal period. The nurse visits the home at least twice a month during pregnancy and discusses the issues such as stages of pregnancy and nutrition and baby care in addition to assessment for violence and drug use. She also attends meetings. And then developmental screening is a big part of what we do in well child care. Babies who are at risk for developmental delay are referred to the Children's Hospital. So assessments can be done either in the home or if for some reason they are more comfortable they can come on Friday mornings and have their children assessed right in clinic. As everyone knows frequently teens live in unstable living situations and so our staff has relationships with a lot of independent teen living programs that exist in the Boston area. And likewise there's school, job training and day care referrals. And we do youth development activities. One example is exercise classes where we paired up with local gym to provide exercise where the staff went and exercised along with the teens. That was very popular. We have done rowing in the past which was very unique and getting kids out on the Charles River who hardly knew where the Charles River was. And finally there are families, grandparents can access our services. Frequently siblings and extended family members receive care through the larger pediatric practice. Families may come in together for care. We run monthly family forums or informational sessions are on topics such as child development and that sort of thing. We use a randomized control trial our CT to evaluate our parenting and life skills intervention. And that consists of one on one individualized modules addressing five core areas which are the child development and discipline, home safety, budgeting and bank accounts, healthy living which includes violence and drug exposure and job readiness an resume. They will help girls write resumes if they are getting ready to look for a job. We also have fathers programming where they receive access to the medical care in the social services either provided directly by YPP or by referral to a community health center. We have run fathers group. I think we have the first one tonight for the next group of them. Our meetings, fathers don't like the term groups they prefer meetings. And their based ton

curriculum based on the responsible fatherhood curriculum. They are interactive sessions on manhood, parenting, child development and relationship negotiation skills. They have also done youth development activities. One example is they did rock climbing that they did in collaboration with Northeastern University. The program evaluation consists of three components. We have the health services evaluation, the medical and the social care, which uses mostly quality improvement methods. We have the RCT as I described and we also have had qualitative focus groups. So far we have enrolled 170 mothers and 71 fathers. In the RCT 80% of the mothers have consented to participate but about 68% so far have participated. Attrition for the program as a whole has been very low at about 6% in the first year. The demographics of the participants reflect the population of Boston living close to Children's Hospital. Just over half are Latino and the rest are African-Americans. The mothers were about 17 years old when they deliver their babies. Most receive Medicaid Insurance. Ten percent of the babies have complex medical needs such as congenital abnormalities, prematurity and their care requires a lot of care coordination with home nursing services and sub specialist. That's an area where we become a specialist for teen mothers who have really complex children and that adds a whole layer of complexity. The majority of Medicaid and insurance and about three quarters of the fathers are involved at the time that the babies are born. Looking at the one year outcomes; it's important to know the medical home outcomes. With almost one hundred percent of our babies immunized. A hundred percent having received six well child visits which are considered key outcomes for a medical home in general. Likewise three quarters of the mothers have received medical care and contraceptive counseling and that's delivered by us. Eighteen percent had a repeat pregnancy and 41% of the babies' fathers had come in and had enrolled in the program. And looking at life skills 90% of the mothers and 69% of the fathers had graduated or still in high school. Fifty-nine percent of the fathers were delivering some type of financial support to their children. To summarize successful evaluation strategies during implementation key was involving the entire clinical team and the program evaluation and implementation. Progress on the intervention and data collection are summarized and charted during teen meetings. We have a web based data collection tool that has facilitated data collection by allowing teens to complete the questionnaire in the exam room an in the waiting room or whatever other convenient space is there. I think most importantly is the bonds that have developed between the teens and the project staff. There are many challenges, successful recruits into an RCT is dependent on very clear communication. Teens don't automatically understand what an RCT is or what it means or do they accept that saying yes at the beginning means completing the intervention if especially if they are randomized to the treatment arm. The detailed tracking system is mandatory since phone numbers and addresses constantly change. Overall, we feel that the compliance with the intervention could be better but we found that it's steadily improving as our team as a whole gets better explaining the intervention and enrolling kids. Finally social needs including the depression and exposure to domestic or community violence require a lot of staff time and energy. I think other people have alluded to that today. It's sometimes kind of feels like you are getting mowed down by the needs of the day and that is definitely a challenge when we are trying to implement a scientifically designed evaluation. So the strengths of the medical home are that they allow for a family base. It's culturally appropriate services which engage adolescent parents through their need for medical care,

especially the medical care of their children. Fathers can be involved through time. Fathers often don't want to be involved right at the time the baby is born, once they gain trust with the program. They are much more willing to sit down with the computer and officially enroll. Teens benefit from the communication and resources that are integrated across services across Boston and within the practice. Again, the medical and the social services being equally valued even though this is a medical setting. So in conclusion, teen parents benefit from wrap around services in a medical home which specifically address barriers to care. Integrating medical care and social services with community resources is an effective and efficient model for engaging young family in care and promoting positive parenting and life skills. Thank you.

Applause.

Our next presenter is Melissa Maguire.

Melissa Maguire: Good afternoon. I am humbled, excited, nervous and grateful for the opportunity to share with you today our program - The Responsibility Pregnant Parenting Program. The girls named it. We will call it RAPP. Our program serves run away and locked out youth in the city of Chicago. The Night Ministry has been providing services to run away and homeless youth for about 35 years.

Which, I just need to say before I start. I have the best staff in the whole entire world. As we are talking about implementation and strategies and impact I think some of the panelists have talked about it and I would like to highlight the importance of training and the importance of measuring the capacity of our staff that provide the services to the girls that we serve. Where am I? So our program is an interim or short term housing program for runaway or lock out or homeless mothers age 14-18 and their children. Our overall goal is to increase the housing safety and stability of the young families in our shelter an increase the time between the subsequent pregnancy. We are grateful for the support we receive from the Office of Adolescent Pregnancy Programs and the Family and Youth Service Bureau as well. Prior to this program, The Night Ministry had been serving runaway and homeless youth to include pregnant and parenting youth within all of our homeless youth programs. That includes street outreach, short term housing and long term housing. However, five years ago we embarked on this new journey to serve exclusively and only in one program pregnant and parenting youth in what we would call an emergency or interim shelter program. The main components of our program are a low threshold for services. The only requirement received shelter services is that you are between the ages of 14-18, you are pregnant and are parenting we don't limit the number of children, you have to place to stay and we have a bed. We provide 24 hour intake seven days a week. The length of stay varies on the needs of mom as well as the age of the mom. For those moms who are 17 and younger our main goal is family reunification and our goal is short term services within 15-21 days our goal is to work with community based agencies where they provide family unification services and we provide the housing. For moms who are 18 they can stay as long as 120 days. We address the basic needs, stabilize the crisis and our goal is to reintegrate these moms into the community. What we know about homeless and pregnant teens is they isolate. And through many

services and programs our goal is to help them identify the support systems that work for them to reintegrate them into the support service. We have a service rich environment that has counseling, case manage and groups, groups, groups. Our girls are marginalized in many different groups. They are marginalized as a runaway homeless youth and many of them come into the program not knowing there's other people like them. We know we are all unique. However they didn't know that somebody else was living out of a car pregnant with a one year old. They didn't know somebody else was couch hopping place to place and not able to go to school. When they're sitting in a community where they are hearing other stories they think maybe it's not me and that's our goal. We have an active referral network. We consider ourselves part of a continuum of care. Many times it takes multiple housing options to support the young person. We consider ourselves one of the pieces of safety net for housing. Moms can come back to us multiple times if they are having problems when they left our program. They can come back for housing or services sometimes they just drop by. What I am so amazed with my staff is that no matter what happens when a mom drops by somebody stops what they are doing and they sit down and talk to the girl. One time this girl brought her friend by. She wanted her friend to meet her . family. ; she wanted her to meet the staff, so one by one the staff had to come down. Then when it was my turn to come down -I sometimes do the consequences – she pulled me aside and said now Ms. Melissa, you can tell her this, but you can't tell her this. I said okay we will be fine. So we are the housing safety net for the moms in our program. We follow the Healthy Teen Network. Shout out for them. For our implementation strategy we look are providing housing stability, promoting self-sufficiency and financial stability, we work on engaging the parent with attachment with their family and key for us is healthy teen relationships. For housing, if you walk into our building, we're a small program, we have eight beds and eight cribs - sometimes it feels much bigger than that. But is looks like a home and it feels like a home. When the girls come into the program they comment on that they were so afraid to come to a . shelter. . Actually we have toyed with taking that word out. When I come here it feels like a home and as I said before we, our goal is family reunification for those minors, that is are 17 and younger. Family reunification doesn't necessarily mean going back to the family you came from. Sometimes family reunification is taking the time and providing stability so that young mom can identify oh there was that aunty once that really paid more attention to me or you know my grandfather hasn't called me for a while and identifying the family support system that can support them when they leave the program. Our goal is to prepare them for longer term housing. For self-sufficiency, our overall strategy is to help this mom to move from survival the thriving. So many of our moms are used to surviving moment to moment, day by day. What we are trying to do is to teach them the skills and provide them with resources so they can thrive rather than just merely survive. We have a life skills curriculum that was designed specifically for our program, as much as health and education are key. Our girls don't go to a health center. They go to visit Dr. Soto. They visit people, they don't visit programs. What we try to do is bring as many different people from many different programs and venues into the building to develop that relationship and to help that girl transition back into the community based center. One thing we are proud of is we have a doctor that comes in once a month and she does a group called . ask the doctor. . They are able to write anonymous questions all week. We talk about food. We always tell people if you really want to get to know our girls, come at

dinner time. She sits down at dinner and she starts pulling out the questions and it’s amazing the medical questions she has. As you can imagine a lot of girls have gotten their prenatal care through emergency rooms and our goal is to transition that medical care from the emergency room into a medical home. We do that through the relationships through the doctor. Education is key, we advocate with the liaison in the schools that advocates for homeless service education for the girls in our program. For financial stable one of the things we do with managing income for those girls that are 18 and working they are required to save 60% of their income. A program that our staff developed is an incentive program. They came and said we are tired of giving consequences. Can we focus on positive development? The staff initiated an incentive system where the girls earn points. So by the end of the week, depending on the number of points they earn, they go down to our basement and we have shelves and shelves of donated items and they are able to choose from those shelves what they would like to put in a bin for when they leave the program. What is powerful, the majority of the time they choose things for their children and not for themselves we are going from is surviving to thriving and to actually be planful and have items to help them when they leave the program. For parenting, as we have spoken before, a lot of the girls are reparenting as a child that didn’t receive support or consistent parenting, overall focus of our program is support, to support challenge. We do have a great parenting curriculum. They receive the parenting information in a group and then we staff after the group and then we identify which mom needs what specific skills? So for example bedtime routine is a challenge. She's having a hard time doing the bedtime routine. So whoever is working the overnight work with her on how you give the baby a bath and how you put it to bed. Many of our girls are challenged with the babies sleeping with them, particularly if they have been living on couches or living in cars you don't have, you haven't had the practice to put a child to sleep in his or her own bed. The way we do it is we present parenting in a support to support challenge framework. We support what they have done and support them and then challenge them with the information. Relationship building is key to our program. About 60% of the girls have identified they have left domestic violence our staff probably thinks it's much higher than that. We have domestic violence groups in the community so they can see other girl’s that are experiencing domestic violence as well as we have mental health services in our shelter by a health professional. She focuses on relationships with them. A key with relationship is for them to identify formal and informal healthy support systems. Some of the challenges of our program, as my colleagues have talked about. Youth that come with chronic or undiagnosed or untreated mental health issues tend to be a challenge for pregnant and parenting runaway and homeless young women. We also have a lack of long term housing. The girls that come into our program are the girls that aren’t making it into long term housing programs. We provide them with stability and try to refer them. In the city of Chicago we are the only shelter who provides this crisis service specifically for pregnant and parenting teens. Unfortunately there's not enough to meet the need. We partner. We are always on committees and partnering and sharing resources when there's an open bed in a longer term housing program our girls get on the top of the list we want them to call us. That's a challenge for us. Another challenge for u is securing supportive child care. We talk about the benefit of child care. A lot of our girls have been threatened that their children will be taken away from them by child care providers. We partner with a program call the

Maryville Crisis Center and we do field trips we put them in the van and they go out to Maryville, they feed them and they walk around the child care program and the staff there is phenomenal, the staff even come to our agency is and the staff does event. The majority of our girls may not go to Maryville Crisis Nursery however our goal is to feel comfortable with a formalized child care program. Balancing employment and education is a challenge. Some of our girls are in survival mode they want to provide for themselves. Even if they go home they are expected to provide for themselves and their child. Their survival mode is we all know that but I got to eat. I got to get my baby fed. That's the challenge of our program and the transient nature of the young girls in our program. So when we talk about the transient nature the outcomes we are looking at we looked at about 70% of the girls that have left our program. We are proud of that. Of the minor youth, 17 and younger, 85% were reunified with family. I had a piece of paper. 65% of our girls identified they were homeless specifically for family dispute. For us to have an 85% return rate we are proud of that. It might not be with that family member where there has been the conflict. It's in an extended family member or a place where the guardian supports where they are going. I still have to put pregnancy again from the population we can follow and I have to be truthful about it. That's the group we can follow. At this particular time the subsequent pregnancy rate of 11. You know how we find that out. The girls in our program they stay connected. They know each other and that's an amazing testament. So when we call somebody and say I am making these names up and we say how is it going blah, blah barks and she will say have you heard from so and so and so and so we said no. We get together. We think that's amazing they are still getting together with them. We will say we have them call us. We got to ask them questions and we have a great gift card. I think we talked about that with the dads as well. I got to stop. Okay. The girls that have left the program have transitioned to family agreed upon places. This is all of the girls in our program. The child welfare system advocate gets them into the child welfare system. The 18% is in their own apartment or living with the father of the baby. We thank you very much. This is my favorite picture. This is an activity the girls designed; they came to us and said we don't have showers. So what we do is we have a baby shower. For the girls in our program we said that's a great idea how about you do it. So they plan the shower and they order the food and they get the prizes and we tell them all they can invite a support person to their shower. What is amazing some of them invite the father of the children which we absolutely encourage them to bring. Some of them invite the mental health providers. Those are the only people who are their self-support at the time. There's no way we could have done it without their support and the support of OAPP, thank you.

Our next presenter is Pam Plummer.

Pam Plummer: Melissa I beg to differ with you because at the Center we have the best staff in the world. I love you Melissa but you are wrong. I have the best staff. I am Pam I am from Little Rock; Arkansas the center is a behavioral health care organization. We are a small part of that even though we are not small. We do a lot of different services. Today we are talking about statewide home visitation programs for teen parents. If I can do that. You can see in Arkansas it's greatly needed. It's one of the highest teen pregnancy rates we are ranked 46. We have high poverty rates and we are ranked 50th in the state for

teens not working or in school and unfortunately a lot of young pregnant mothers do not receive adequate prenatal care. I understand about the 12 year olds a lot of our teen parents are cyclical, it’s intergenerational - a teen parent who has a child. At one point we had a 25 year old grandmother in our program. That really brought it home to me. We have a great need in Arkansas. I am going to give you a little history. We began serving teen parents more than 20 years ago in the Little Rock area which is the center of the state and capitol of the state. We were able to expand that program through an Adolescent Family Life Care grant through the Office of Adolescent Pregnancy Programs and we have spent the last 12 years really working on that since 2002 that we were able to expand. We spent the last 12 years working on a home visiting program, we have made a lot of mistakes and we have learned from those mistakes. We have developed what we believe is a great program for supporting teen parents, pregnant parenting teens after we call it The Thrive Model. I am glad you used the word thrive because it's close to our heart. The thrive model knows that is all teen participants are different. I believe that's a lot of things I have been talked about. They have different needs. What the thrive model does - it is works to identify the needs that teen parent have and addresses those needs and provide solutions to those needs. We're a mom visiting program. Going into the home allows a family support worker and that's our home visitor, we call it family support visitor. We allow them to assess the home situation. It allows them to know other family members. Because as we said relationships, relationships, that's the key to success of our program. The family support worker developed trusting relationship with that teen parent and family. Home visit occur as needed and they decrease as the team becomes more dependent. For the home visit the curriculum we use is for parents as teachers and the born to learn curriculum. Through that we go through the curriculum. We work with the teen parent on anything they need. We work with them on identifying baby basics such as doctor and feeding and we do safety work with the children sum we want them to leering about child development and age appropriate expectations. We have a lot of people come into the program and expect them to be potty trained at six months. That can cause major issues. We work with them on positive discipline an honestly if that child needs to know how to do laundry we do that with them. Anything that child needs to succeed and I call them a child you know that teen parent needs to succeed we are going to work on. We also do group meetings because we find that the teens like group meetings. It gives them a chance to come together and connect with each other and bring their babies and show off their babies and have a nice meal together. We do curriculum and a nurturing program for that. We provide child care and transportation. Another thing about thrive is that transportation is provided as needed. We help the prenatal girls make appointments and we take them to them. That is a big barrier. We do work to have them become more independent as they go. Our program objectives we want them to graduate from high school or receive their GED and hopefully they go onto more education. Delay additional pregnancy. We want them to learn about their social support so they can identify services and obtain services if they are pregnant. We want them to receive prenatal care and we want to improve family relationships. For the child, we want them to be full term and at a healthy weight and receive well baby checkups and be up to date on immunizations. We also use the Ages and Stages Questionnaire -- I'm from Arkansas - to identify any developmental delays and provide referrals as necessary, so in 2005 we got, we partnered with another adolescent family care grantee—Healthy Connections.

They are located in Nina, Arkansas. They were doing a similar program as we were doing, so we got together and proposed to do what we call the STAR program or the state technical assistance and resource program. STAR because they were working in the very rural setting and we were working in an urban setting and yes there are urban areas in Arkansas. Not quite like other urban areas but they are urban to us. We have the experience to work with both. We were able to reach out. STAR hopefully gathers from our experience and we can go out and we can help an agency in the community learn how to start a home visiting program or replicate the thrive model and we start with helping them identify funding and grant writing and recruitment, documentation, reporting and family support workers training. We do all of that through group meetings. We developed a manual. We have on site visits. We also developed family support worker training DVD that shows examples of how important that family support work in the relationship is. So that is how we do it and we are able to reach a lot of teens that would not otherwise receive services. We have I believe been a successful as we have because we go into the community and we want to work with agencies who are in that community and who are familiar with that community because we believe that's how they are going to be successful. We work closely just like teen parents all agencies are different and they have different needs, so we work with them the first thing we do is sit down and identify what their needs are and develop a program to go with them. We also know that it's very important as I said a lot of our areas are extremely rural and have very few services. We want them to go in and develop a service in their community. Where can we find the services what's the closest location we can help these teens get the services they need. We provide them with the assistance and training. We do provide ongoing continuous support on calls all the time, e-mails, visits an all of that. Also, extremely important to our program is our relationship with the Arkansas Children's Trust Fund (ACTF). ACTF helps us identify agencies and communities that want to begin new programs. They also provide funding, which is key. An RFP is issued annually and included in that RFP is that each site works with a STAR program. Children's Trust Fund has learned that when STAR goes in and helps with a program they get started quickly. They are serving clients a lot quicker than their previous grantees. We have experience with rural and urban. We have strong collaborations with Arkansas Department of Health, Arkansas Human Services, and we work with Arkansas Workforce Department. We are used to, we have a lot of funding sources that we work with whether they are private, local, state or federal. We have experience to help. We believe in the thrive model because we have seen so many positive outcomes. Over the past eight years our subsequent pregnancy rate has been averaged below 7%. We also have a high, high school graduation rate. I can talk all day. I have no time. I guess it's time. We use the Adult Adolescent Parenting Inventory (API). That's showing promising trends with what you evaluators call it significant gains? In parent-child nurturing. We are excited about that. We are also our babies get immunized and receive well baby checkups. If we have to take them we do. Here's Arkansas and the blue counties in the center is our Little Rock is and the other counties is where Nina is. The orange red counties are the ten new counties that we in the past five years started new programs in. The yellow counties are six existing programs that is the Arkansas Children's Trust Fund ask us to step in and maybe provide a little assistance in specific areas. The gray counties, we are very excited that we didn't the Children's Trust Fund received an Office of Adolescent Health pregnancy assistance grant. We are a

partner with them to provide the training. Those gray areas are potential PAF sites. An RFP was submitted and different agency haves replied to that. Today the Board of Children's Trust Fund is deciding who those grantees will be. There are a lot of challenges rural sites have fewer resources which make it difficult. Sometimes hiring qualified staff and the being able to be able to develop the relationship is so important. Monitoring the fidelity is often difficult. We have worked hard to have easy to use forms and reports. We try to ensure they all receive the same training after we do side audits and visits. Traveling can be difficult. This past year we had tornados, floods, and ice storms which delayed things and we will do it next week when the weather is better and funding, always, always, always, is a challenge. And the past four years our STAR programs has served more than 80 teen moms and 700 teen dad program. A 1000 infants and children and more than 2500 other family members. Even more exciting that in the next year alone through our AFL grant and our PAF grant we anticipate serving more than a thousand teen moms and 800 teen dads and we are excited about that. We are working to break that cycle in Arkansas. Thank you very much.

And now Dr. Keneca Boyce.

Keneca Boyce: Thank you for the introduction Dr. Clark and again I would like to extend a sincere appreciation to OAPP for their vision that gave birth to the symposium – no pun intended. I am Dr. Keneca Boyce. It is my pleasure to present on the implementation of a model that's very promising in strengthening family preservation and healthy choices for parenting and pregnant youth in foster care and their babies. I am going to provide background information and key characteristics of model and then I'm going to utilize the theory have change I have developed for this model. Those of us who are entrenched with implementation know it's a word but it's really a task once you take it from abstract to concrete with the respect of the creation of an idea. I am going to utilize it there to explain change and implementation. Inwood House is actually a part of the Crittenden family of agencies has been around for 181 years. I think it's safe to say there's been a little bit of practice in refining and customizing this model for implementation. As a leader and innovator in the teen pregnancy prevention, youth development and family support, Inwood House is dedicated to helping young people take charge of their lives and become healthy and self-reliant adults. The statistics tell us 8,000 babies are born to teens in in New York City each year. We don't know how many are born to teens in the foster care system. The data collected at the Inwood House revealed that the young people in the foster care system who are pregnant and parenting are an average of 16 years old. They come with history of multiple foster care placements, history of multiple traumas including physical and sexual abuse, and history of unmet mental health needs. It reminds us of the complexity of the work and but also a model that's customized to address the unique set of needs for this grown up of American population. It should be noted that this is an evidence informed model funding provided by the Office of Adolescent Pregnancy Program in 2000 supported a five year evaluation to assess the extent to which a long term continue of care for pregnant and parenting youth in foster care would impact their education and employment and their parenting success. Findings reveal that increase access to multiple services in addition to increased access to multiple supports resulted in positive gains of the areas of education, employment and health and

healthy relationships and much more. Inwood House formalized their model as a teen family learning center. It's implemented within a blended model mother child residential setting. Its referral base with rolling intake and a total capacity of 30 with the respective breakdown provided. It's further defined by a teen family friendly culture of support. We have heard about that today. That's with 24-7 peer and consistent professional staff support. In addition to intentional inclusion of the father of the baby, the biological family and community supports. Now we are going to begin to take a look at some of the key sections of the change and I will provide summaries to further explain implementation. Here we have the high priority services. These are all informed by literature, research and trends. The high priority services are actually the programmatic building blocks that inform service delivery and outcomes. Pregnant parenting youth have an opportunity to temporarily reside at a mother child residence and they receive an array of skills to address a myriad of missed milestones and reoccurring setbacks as a result of strained or unavailable family support which is compounded by the history of trauma. This model affords pregnant and parenting youth in the foster care system a safe space to process their past, but also an opportunity to redefine a healthy future orientation for themselves and their babies. Youth receive information and develop skills in each high priority service area in order to prepare for parenting as a younger adult. Each high priority service area requires specific resources and activities that drive practice, implementation and outcomes. Of course with the interest of time I did have an opportunity to indicate all the resources and activities. This gives you an idea of some of the resources that is goes into executing our high priority services. Mental an emotional health are critically important for stabilization. Our young people disclose complex histories of trauma and victim that must be assessed and understood and addressed at the onset. Resources like social workers and as indicated by the asterisk collaboration with full circle health and a culturally competent trauma informed mental health provider support key resources like - we have updated psychiatric and psychological evaluations for all of our young people. These tools I cannot under score enough because they are extremely valuable because they set the foundation for defining mental wellness in the lives of pregnant and parenting youth in foster care and their families. Medical and reproductive health is essential for achieving promising birth outcomes. Resources such as an onsite LPN in collaboration with New York City hospitals, support activities like medical monitoring and sexual health groups. The very high priority service of education requires a great deal of effort. At intake our young people will often disconnect from the academic setting for an average of two years and upon further assessment they have been over looked and pushed out or placed in settings where they have not been engaged or challenged. Education, specialists and tutors and testing resources along with the very necessary partnership with the department of education supporting the development of an education plan and attendance monitoring and college tuition so we can expose youth to secondary education. In order to further address the links between teen pregnancy and poverty, career development and financial literacy partnerships are critically important for developing a pipeline of young people that are extremely talented. Our internship and culinary program is quite popular. Work experience and exposure and opportunities that build upon their strengths are nonnegotiable when it comes to supporting pregnant and parenting youth in the foster care system if they are in fact going to achieve self-sufficiency. We have heard a lot about it today but when it comes to parenting and co-

parenting the literature says that is the involvement of the dad that leads to better wellbeing for the baby and the family unit. Resources like maternal health and parenting specialist in addition to fathers account specialist support activities like co-ed co-parenting groups where learning and child development skills can take place in the same space. Supporting pregnant and parenting youth requires a great deal of professional expertise, interdisciplinary collaborations and comprehensive services and holistic practice the customization of this model is driven by the awareness and the intentional practice to bridge the gap between adolescent development and parental milestones, all in effort to prepare our young people to parent as a young adult. What you have here is an illustration of the teen family friendly program culture which is really central to implementation. These are some of the strategies that we use to really anchor program compliance and buy-in as well as foster that bridge that I mentioned with respect to adolescent development and parenting milestones. I will quickly highlight a few. Welcome to Inwood House give basket helps young moms quickly acclimate as their new and expect roles, mommy and me reading programs foster literacy, mother and infant healthy bonding and there's family night which helped the young people experience healthy interactions in a supportive environment. Some of the outcome that are expected for pregnant and parenting youth in foster care are family planning, Occupational advancement and healthy birth weight and full term delivery. Those are some of the few. With respect to this model it really is about breaking cycles. The impact of this model is that it breaks cycles related to infant mortality, intergenerational foster care and it breaks cycles of poverty. It actually allows for portability and replication and healthy choices for teen parents and their babies. It was actually a challenge putting together this slide titled . Challenge. because there is so many. I've identified challenges across the area of practice, research and policy. Policy - As noted earlier pregnant and parenting youth in the foster care system live with the emotional voids of life that's character raised by unimaginable traumas, a great deal of family instability and inconsistent exposure to violence and revictimization. Their day-to-day is spent with the uncertainty about their since of self or their personal identity with no safe space to process all that's transpired in their very short life span and to add to that these young people are expected to be self-sufficient at the age of 21 according to current foster care policies. I think for those of us who are present and those joining via webcast. If we are honest with ourselves we can think of people whose childhood does not match -- yet they to or we still needed support beyond the age of 21. I am getting a lot of nods in acceptance. So that said it's critically important in our outline that policy at it relates to the -- compliment research and practice knowledge. Policy support of pregnant and parenting youth beyond 21 is vital because it has to do with the increased risk for two innocent generations to fall through the cracks. In doing so they are competing needs but we must prioritize policy that is are going to address barriers to economic efficiency and sexual health. Pregnant and parenting youth in foster care will benefit the efforts of the foster care system to effectively serve these youth. With respect to the practice strengthening approaches for pregnant and parenting youth must continue to address the collaborative spectrum of services and outcomes. In doing so we can achieve scale through the provision of sexual health, resources for prevention early intervention and teen family support. We often hear the saying that it takes a village to raise a child. Well, the pregnant parenting youth in the foster care

system are in fact relying on the American village. I wonder are we really up for the challenge?
Thank you.

Applause.

Dr. Clark: Thank you for those presentations. As we mentioned earlier questions and answers will come from cyber space as well as the audience. If you would like to line up microphones to prepare for the question and answer session. How many minutes do we have? Ten minutes for question and answers. I have one question here for Melissa Maguire we can start with. This question again comes from our webcast audience. Is substance use a problem or a concern and is it addressed or assessed? I would think that this would be a problem or a concern particularly among homeless after run away youth.

Melissa Maguire: Surprisingly yes we have some young women that are challenged with their own substance use and abuse. More than that, their challenge is with their family members or partner who is are abusing or misusing substances. That's part of war assessment it does not deny service. They can still receive shelter services. In our mental health partnership with the mental health provider that come into the program she also provides assessment and referral for substance use an abuse, but really it's more of the mental health than the substance use with the pregnant and parenting. The research has shown that many times with homeless young moms they become pregnant and they look at that as a time to stop using and abusing substance -- there's a study that they did in California that talked about when a young person is run away or homeless youth she becomes pregnant you have a window to intervene so we do see in some cases they might have a history of substance abuse they stop many times when they become pregnant.

Dr. Clark: Thank you. Any other responses from the panel?

Next question: This is for Dr. Boyce. You were going so fast. I wanted you to spend a little time talking about the parenting programs at Inwood house. I have had a chance to visit a couple of them in years past if you can spend a little bit of time since we are here the adolescent pregnancy.

I already put my hat in the ring for the 20 minute presentation to cover that next time. I mentioned that we have maternal health and parenting specialists. With that comes a lot of different resources, so part of that includes with respect to parenting understanding that we are putting the pregnancy in the context of the adolescent and recognizes they get a lot of support around that. We actually provide services on the front end that informs a young person about what's going on with their reproductive health as they prepare themselves for the pregnancy-- with that we have a dual matching program where all of our young people experience support prenatally an post -- to labor it can be a terrifying moment in young people's life. We also have a video home training program. Which is amazing it really focuses on reframing parenting and a lot of our young people do not have the positive experience and it hones in on the positive interactions? It's captured on a DVD and the young people after they have completed that session actually get to walk

with that. I think what's most powerful is that you can see the transformation and the young person recognizing that I do have the competencies to parent effectively. It's enduring with respect to how they pass it along to their peers as well. I was hoping to have that question. There's also support on the postnatal part because we know that can be a very lonely time as well for our young people recognizing that now I'm responsible for this real life baby and what am I going to do with that. There's a lot of support on the back end. There’s still support there. Our blended model I spoke about earlier really lends itself to maximizing on this one stop shop residential setting where young people have the peers they can ask questions who preceded them in certain milestones of parenting and then they are also able to share their new milestones. I am sorry - the fathers count program which is a part of our parenting services and really engaging the young men. We engage our young men from the point of intake. They are -- it's warming to the heart when you see the father come to see their partners and child. Young men are invested and they do want to be part of the parenting experience.
Thank you.

There was a slight applause.

Next question please.

I am with the National Institute for Reproductive Health. I really enjoyed listening to your presentations. I am wondering if any of you could go into. I heard several of you speak about reproductive health as part of your programs. I feel as though many times we speak that to teen pregnancy and we equate that to teen if any of you could deal with abortion access and how you deal with that in your parenting youth.

Bernadette Strode: I will start. Our case managers don't encourage it. They don't bring it up. If the student does they will seek information on take that student to Planned Parenthood or other agencies and that's the way we address it.

Joanne Cox: we don't use any AFL funds for that. (laughter) because we live within a medical home there are medical providers within that medical home that are not connected to AFL that can provide counseling about choices.

Alicia Richmond Scott: One point of clarification though in terms of for those organization that is are funded through with AFL funding while abortion in our legislation it is very clear that we have to remain neutral about abortions, I think that the programs do a very good job of talking about reproductive health services that they can provide and receive and I think that they cover the spectrum and not necessarily about abortion per se, but in terms of other contraceptive. I want to make sure we are responsive in terms of that piece as well.

Melissa Maguire: Because again we are a short term program and our goal is reintegration into their community. We have found that our, the girls in our program prefer choice and so we even give choice of providers, so as I said we have a provider that come into our program sum we have partnerships with teen health clinics as well as

community based clinics. For the girls in our program we do an awful lot of listening to find where they feel safe and supported and where they intend to stay after their leave our program and for those that need bus transformation. We have had staff go with them and we have had people come into our building as well. What we have found with our young people it's important they have a choice in their reproductive health whatever they be. They can shop if they are not treated well they can go someplace as well. That's what we do with our girls.

Dr. Clark: Thank you for those responses. Any final questions?

Good afternoon. My name is Sybil Davis. I'm from the mobile team center part of Mobile County Health Department. My question is for Ms. Plummer. We have a program that's very similar to yours. I have three questions and they are short questions and we do use the PAT curriculum as well as the back to basic curriculum. My question is what determines the number of visitation and irregularity of the visitation of your family support workers and the next question is what's the educational background of the family support workers and what's the number in their case load?

Pam Plummer: Good questions. The number of home visits is really determined by the need of the teen parent. We do have a level system we use that when they first come in they get more visits weekly visit and as their needless sons then those visits are lowered we also have as a teen graduates from the program they don't really leave because they tend to want to come back. We call it creative outreach. We will still see them and talk with them and visit with them. Once they join in they kind of stay. The level of education for our family support workers. We prefer to have a college degree. If they have a lot of experience that can be you know replaced with that. They are para-professionals. We make sure that they receive a lot of training through our family support training and visiting training and your third question case load. They cannot handle a case load of more than 20. If they have a lot of new teen parents that is' going to be difficult because like I say we do provide trance proration an assistance. They may spend all day with one teen parent. It varies depending on if they have teen parent that is have been in the program for a while and don't need as many services they might go up to 25. They keep it around 20.

Dr. Clark: We want to thank you for your attention and your time and certainly your insightful questions. Just one more round of applause for our panelists please. Now back to Reesa. >> Reesa Webb: A special round of applause for Dr. Marc Clark.

Applause.