

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

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**Research to Practice: Applied Research Approaches for Pregnant and Parenting  
Adolescents – Part 2**

We are ready to reconvene our panel. Please sit down and stop your conversations with your neighbor. Our first presenter in the second part of our panel is Dr. Beth Barnet. She's the Professor of Family and Community Medicine at the University of Maryland School of Medicine in Baltimore. She's a clinician and educator and a program builder and evaluator, since 1995. She is a recipient of an Adolescent Family Life research grant. I also at this time would like to introduce Janice Key who will be presenting immediately following Dr. Barnet. Dr. Key is sitting next to Dr. Barnet's right. She's a Division Director of Adolescent Medicine and Professor at the University of South Carolina. She has numerous publications in several areas in addition to teen pregnancy prevention. She's experienced in adolescent smoking cessation and obesity treatment and prevention. I would like to welcome Dr. Beth Barnet.

*Applause.*

**Beth Barnet:** Thank you and good morning I am pleased to have the opportunity to speak with you all this morning. I am going to talk about what works to prevent rapid repeat mothers. So as we heard already from Dr. Beers that adolescent child bearing has decreased over the years but even so in 2008 there were almost half a million births to U.S. teens. The majority or to older ages 18 and 19, but a significant number is 15-17 year olds. Of these births one out of five of them are rapid repeat births by the time the teenagers in the United States has reached 20 years of age 18% of them will experience birth and one out of four of them will bear another child within 24 months. So why does this matter? Well repeat teenage birth is associated with greater risk of prematurity and low birth weight a school dropout. Long term poverty. Dependence on public assistance and higher levels of stress, poor mental health and cognitive behavior in the children of teenage moms and the cost estimated to be over 9 billion-dollars, so research has told us some of the factors associated with rapid repeat birth. With age this is mixed findings. Eighteen -- more likely to experience rapid repeat birth. Race and ethnicity with African Americans and Hispanics more likely to have a rapid rebirth than whites. Partner relationships play a significant role in many of the outcomes of teenage childbearing and that's true of rapid repeat pregnancy and birth as well. Teenager who is live with or lived with or cohabitating with their partner are more likely to experience a rapid repeat birth than those who are not. Low cognitive ability and the types of contraceptives. Long acting like the less used such as the IUD might have more effective than other types of contraception. There's emerging evidence that depression maybe a risk factor. So over the

years there have been many interventions tried and tested looking at reducing repeat pregnancy and birth. They have been done in a various types of settings from clinics to schools or community based. Lots of different service providers types have been looked at from doctors and nurses, social workers COMMUNITY outreach workers and interventions have consisted of a myriad of types of actives providing health education an home visiting an social support an other kinds of support an teaching kids life skills an employment training an there's been a couple of studies that looked at paying teenagers not to get pregnant. All of these has sort of a really left us with some very modest impact in what they're able to achieve. So as Dr. Beers talked about earlier. What are some of the factor that is go into effective programs. She talked about some of the hospital based programs and alternative schools. She mentioned then there has been a lot of focus on home visiting programs that the two programs she mentioned. Home visiting by nurses who delivered protocol and support an education. Another home visiting by training by big sister or mentors. Both these programs were evaluated by randomized trials. They are very rigorously evaluated and they, but they have been focused on first time adolescent mothers. They begin during pregnancy and continue for quite a long time until a couple of years postpartum. They share a couple of features. They are moderate to high intensity and they occur over time. They are working within a context of a caring relationship between the teenager and a caring adult. I am going to talk about one of the programs I have been involved with over the past couple of years called computer assisted motivational interviewing. So what is motivational interviewing? Many of you are familiar with this. It's an imperially validated counseling style. It's been shown to be effective in helping people to change a whole host of unhealthy think behaviors. It's a strategy to employees or raise awareness between an individual stated goals what they stated they want and what their behaviors are. In doing this type of counseling it helps to facilitate an individual's own internal motivation to change. So when we talk about the specific components of this computer assisted motivational intervention. This intervention was conducted by trained community outreach mentors who delivered by weekly to monthly home visits. There were a number of main components, main activities that these home visitors would do. First they guided the teens through a parenting curriculum that was culture rally relevant for the population that we are dealing with. And the parenting curriculum had child, age and developmentally appropriate specific models. There's care management of issue in stay anything school an getting back in school and getting health care and housing as we heard we already mentioned is an unstable situation for many of the youth we care for. The home visitors provided support for the teen and family. We had an outreach component to the young fathers. And then the CAMI and MI device itself. It was conducted after the fourth home visit. This intervention began during pregnancy and continued through two years post-partum. Just to say a little bit about the CAMI itself. This was customized software that we built that aimed to assess a teenagers risk and readiness to change. So the teen sat down and answered a whole bunch of questions relate today her reproductive health risks and behaviors. Computed her -- reproductive health behaviors and a summary risk print out was generated and which the home visitor that we called a CAMI counselor then conduct add 20 minutes stage session. This is repeated every three mobs until the child turned two years old. We tested the CAMI with 235 high risk pregnant teenagers. We recruited them in their third trimester from five prenatal clinics in Baltimore that served low income

women. These 235 participants were randomly assigned today three groups. The CAMI plus home visiting all the components I described. The second group receive it had CAMI only. The home visitor and the counselor would do just this CAMI counseling session on the third group was a usual care control. These received their usual health care out in the community. The intervention I just want to stress. This is conducted in teen's homes or other settings. It was not a clinic based program. This is the characteristics of our participant group at entry into the program. On average they were 17 years old, but the range was between 12 and 19. They were almost all African-American. They were about 30 week's gestation at entry. The majority had medical assistance. They were ensured by medical assistance. I want you to notice that 39% were not continuously insured. We considered this a particularly high risk group. Virtually everyone in our party's participants was eligible to receive Medicaid. For various reasons they flipped in and out of coverage, so then were often it became a barrier for accessing health care and other kinds of services. At baseline 42% had dropped out of school. Many were depressed. About a third of our participants were depressed. Eleven% of the sample already had a child. About three quarters were in a romantic relationship with the baby's father at the outset. I can tell you by two years post-partum when their index child was two years old that number dropped to 29%. These young fathers were sometimes not so young. They were older than the teen moms and some of them were adult men. So our main outcome that we actually looked at many outcomes, but the one I am going to talk about today is rapid repeat birth. We measured repeat births using birth certificate data and we matched our sample to birth certificate in Maryland. We were able to match one hundred percent of our sample so I can give you outcomes of whether or not a teen in our program experienced or repeat birth or not? This slide shows you that the distribution in by group of the proportion to experience a repeat birth. You can see in the controlled group. It was 25% and in the CAMI only group -- how do I get rid of this? Okay. So 17% in the CAMI only group and 14% in the CAMI plus home visiting group this is significant that the P equals .08 level. We also did. -- sorry a technical glitch. You can see 25% in the control group and 17% in the CAMI only group and the 14% in the CAMI plus only group. We have models that tell us the time -- what I would like you to take away from the slide is that the time to repeat birth was greatest in the CAMI plus home visiting group. The second longest in the CAMI only group and let me say it the other way around. It was shortest in the CAMI plus home visiting group and CAMI only group -- I am still saying it wrong. Anyways let me just say that compare today the controlled group the cadmium plus home visiting grown up had a 45% lower risk of a rapid repeat birth and that was a significant P less than .05. We conducted a cost effectiveness analysis. We found that the average, so the intervention itself took place over about a 27 month period. For those 27 months the cost per teenager was about 1400 in the CAMI only group an 2700 in the CAMI plus home visiting group. The cost per prevented repeat birth varied between 15, 000 for the CAMI only group and 19, 000 for the CAMI plus home visiting group. Are there subsets to which this might be more or less cost effective? So we conducted what are called subgroup analysis or scenario analysis where we said okay let's did I have did I have -- by race an age. The take home message from here. Risk is along the bottom with left side being low risk and right side being higher risk. What you can see is as the risk level goes up the cost effectiveness goes up. As the risk level goes up the cost per prevented repeat birth goes down. So just to summarize what do we

know about effective programs for preventing repeat birth in adolescent mothers. Individualized support by well-trained and appropriately trained staff is very important. Counseling and education over time and the context of a nurturing relationship also important. You got to promote educational achievement, a reason to look to the future. And motivational interviewing using interactive technologies also appears to be a promising approach -- and feedback to help motivate the teen but also I want to stress you got to tailor to it the teen's age or risk or readiness to change and it needs to be culturally relevant. Just to sum up in a few words I think that we can say about our work is am I as helpful? That's the CAMI only group. High risk teens need additional intervention layer was a greater frequency and more intense is and broader scope of activities after services and that's representative in the CAMI home group.

Thank you very much.

*Applause.*

**Dr. Janice Key:** Thank you Beth. My name is Janice Key you can see how committed I am to the field of research that I have here today. I would like to thank for the support that allowed us to develop the model I am going to describe. Before I start I want to say a shout out to my friends in South Carolina who are on the webinar. Even though I am thanking you for including me I think this topic I was given is one of the most difficult ones which is the education and employment of teen mothers not the question of do they have lower educational employment attainment that's true but is it caused by pregnancy or is it merely associated with all the other risk factors? Many years ago I started working with teen mothers when I became a mother 30 years ago. I started being interested in mothering and qualities of mothering and noticing teen mothers. Thirty years ago I believed what Arthur Campbell said in this quotation. Arthur Campbell was the chief of the naval statistic branch of the national center of health statistics. He said the girl who has an illegitimate child at the age of 16 suddenly has 90% of her life's script written for her. She will probably not be able to find a steady job her life choices are few, and most of them are bad. That was caused by that teen pregnancy. There was a lot of data that led us to that conclusion. The fact was that most, half of teen mothers had a 50% lower graduation rate than their peers. For example Dr. Furstenburg's followed a group of teen mothers. There was a 50% lower graduation rate. I looked at data from U.S. vital statistics and the graduation rate for teen mothers was 32% compared to 75% amongst girl who is delayed teen birth until their 20's. That gap in graduation rate continued from the 50-60's 70's and when Dr. Upchurch looked at the trends in graduation rate in teen mothers compared to those who delayed teen birth. If you looked at it from the other perspectives, if you asked girls dropping out of high school. Half of them said the reason was their pregnancy. And of course. What's our stereo type? The family that lives in public housing, a family headed by a single mom and that family started by a teen pregnancy. It's a fact that 80% of teen mothers will receive public assistance at some point. Forty % will still be in poverty at age 30. They are less likely to graduate from high school and more likely to live in chronic poverty. The complicated question is, are those facts caused by the teen pregnancy or was that girl already at risk of dropping out of high school and living in poverty. The two things to consider. One is the selection effect. All of the risk factors for pregnancy that we look at ethnic background and family structure

and single parent in the household. Family who's already in poverty. Participants who didn't graduate from high school and mother had a teen birth all of those are associated with not completing high school and they are also associated with getting pregnant. Secondly the differential outcomes this is a new idea that I think is very who are the considering. I am a pediatrician. My background is the look at individuals not groups. It makes sense to me that teen mothers are not a homogeneous group that are equally affected by their pregnancy. Every individual is affected differently. I have to open my mind. There may even be situation where is they consider or there is an actual advantage to teen pregnancy. I have had patients relate to me similar stories about the advantage of having a teen pregnancy in the violent public housing situation where they live. This is not rocket science. This is much harder than rocket science. Because we are dealing with real human beings that are unpredictable. We can't randomize a trial where we take an equal group of girls and randomly decide who will get pregnant and who will not get pregnant. We can't do that. We have to look in other ways. One way to look at it is a very clever experiment that looked at a natural experiment. In other words girls who became pregnant and those who had a miscarriage compare today those who continue their grades and give birth. There was a slightly lower high school graduation rate amongst those who had a birth rather than a miscarriage there was only seven% lower, but over time there was an Equalizing when you considered a GED. Another way to look at it is long term follow up. Those same researchers found their cohort many years later how were those women doing in adulthood? They were not doing as badly as we expected. Their high school graduation rate and GED rate rose as high as 80% and two-thirds were working full time. Then considering differential outcomes several recent studies have looked at that one just last year looked at the graduation rate of teen moms when considering her family structure. Girls living with both parents were more likely to graduate from high school. That's true of all teenagers. In looking at add health of longitudinal data of teenagers when we consider just looking at ethnicity there seemed to be a differential effect between African-Americans and Caucasians in that Caucasian teen moms were much less likely to grand jury wait from -- graduate from high school but that wasn't seen in after American teen moms. And then lately the looking at the theoretical advantages of delaying a birth compared to an early birth there maybe advantages of bringing resources to that family or even health outcomes of baby. There may be some population where is the women gets older living in extremely poverty is not as health think as in her 20's. First of all teen mothers are not homogeneous and they each have their individual strengths after risks so there's obviously going to be differential outcomes to teen mothers. Secondly we should look at the costs not merely to the teen mother but to her child and children that's where we may see the spiraling effect in her family of education and poverty. And then the costs of a repeat teen pregnancy are not as well-known as the costs to that first, the consequences of that first pregnancy. I think they are much greater costs impact of the second teen pregnancy. I myself have changed my opinion and my viewpoint of teen pregnancy. Thirty years ago -- caused a girl to drop out of high school and live on poverty. Was it cause or effect or was it just association. Now what I think is what difference does it make? Right? She's at risk of dropping out and is going to affect not just her but her whole family. There are many different models that try to help these girls graduate from high school. We have a wonderful home that's more than a hundred years old. School based peer support that are role models. Parenting classes. Child care at

school. Teen tot clinics and community GED grandmothers. Our model is called the second chance club. It was named by the original members; these are my wonderful colleagues that started this program. Mostly January, Linda -- and the second chance club have case management, peer support group and medical care. The unique things about this program are it's led by a social worker rather than a nurse or a peer. And the social worker is based at the school, but makes home visits. And the other unique aspect is the peer support group which happens at the school during a nonacademic time of course you feed them and you don't have a teen group without food. It's educational but it also is facilitated by the social worker to become basically group process. And the medical care basically follows the teen tot model. Here's our survival curve, flip backwards from the way both was showing hers. This is days until the event of the subsequent birth. So our teens had a less 50% decrease teen birthrate compared to propensity match controls. These were supported by OF. When we looked at high school graduation rate. We had overall a 31% graduation rate and 31% graduated out from high school an two% from GED you are saying that's awful well the graduation rate at that high school was 27%. Actually our girls had a higher graduation rate and the overall students at the high school. If we looked at comparing different groups those that graduated were less likely to have a subsequent birth an 11% than those that dropped out at 27%, so thank you.

*Applause.*

**Dr. Trina Anglin:** We just heard two really great -- we are asking our esteemed panelists who had astute comments last time to do the same for these -- so Kristine it's your turn.

Kristine Andrews: Hi again, are you hearing me okay this time. I think that both of these were great presentations and really emphasized the point that you know this is not a who knowledge knows group. We are talking about the same youth often times, right? Whether we are talking about those that are in juvenile justice or child welfare or dropped out of school. It's the same youth that keep coming up. The youth are having co-occurring issues. We really need to re-think and focus our efforts on kind of unraveling these complexities and really getting at like what the root causes? Why are these teens or population more susceptible or more vulnerable? I think that without really prioritizing and looking at beyond their observe behaviors and getting at the core of the whether it be mental health or abuse or family turbulence or poverty. Those things that are leading to the pregnancy to begin with. The intergenerational, the cycle is not going to be broken. The subsequent pregnancies are going to continue to happen. I think it's beyond the symptoms of just the teen is now pregnant. As far as Dr. Barnett's presentation I thought that involving technology and some capacity is really fascinating. I am really impressed with how individualized the technology can be to that person and give up personalized assessment. The point that these high risk teens are those with co-occurring issues and need just more than a program. Just as the technologies individualized really thinking about how do you tailor the individual service that is we provide to those teens? And as far as Dr. Key's presentation which comes first the chicken or the egg? Research has shown that teens are disconnected from school almost a year on average before they become pregnant. Emphasizing the point these kids are disconnected to begin with and support things like tutoring and youth intervention are things to begin with.

**Sarah Avellar:** We reversed order but I'm still in the same place that's good. I like stability. It's starting with Dr. Barnett I thought this was an interesting program. I love the examples of the print outs of your at high risk with the red flags. Again, I'm on my soap box to see another randomized excellent properties for isolating the effects of a program. I was surprised actually by the difference between the only and the CAMI plus which was much smaller than the difference between the two CAMI groups and I couldn't tell from your slide but it looks like that the difference between CAMI only and CAMI plus is not significant. That's an interesting thing to think about in terms of the difference of this enhanced intervention and it may not be adding that much in terms of the repeat pregnancies. But it's also possible given your sample size that it's not adequately powered to detect a difference like that. You might want to be powering your studies to detect the smaller difference between these two groups which leads me to another point about the importance of replication in evaluation and it's great to have strong designs. It's even better to have more strong designs and independent samples and different evaluators or different providers because as we all know you can have a very charismatic provider who can make a huge difference. You want to be able to replicate your program and samples and other providers just something to think about if you are doing additional research. In terms of Dr. Key's presentation another really interesting program and I like it's a comprehensive model and offers different types of services to really try to help teen moms in their life. I think the results are suggestive of the programs impact. I think it's difficult though to really use these results to determine the effectiveness of the program. Dr. Key herself mentioned that pregnancy may actually not make a difference for some teen moms or may improve outcomes for some teen moms. It's difficult when you only have outcomes for your treatment group to know again if that was the effect of the program or if it was something else for instance the pregnancy itself. I think this does look promising and does suggest a need for additional research. I just wanted to again get a little bit on my soap box and speak more broadly in terms of evaluation research. The importance of linking your outcomes with a logic model to think about what is your program supposed to do and make sure you are measuring the outcomes and focusing on the outcomes. Not guilty just as the panel I have done a lot of evidence reviews the tendencies to throw or measure everything and throw in the kitchen sink because you are hoping for so many differences that can be problematic. The more comparisons you do the higher the likelihood you are going to find statistically different by chance. It can be problematic you don't know if you are really achieving something or if you found something by chance because you are looking at so many outcomes. That's not just to the panel but that's my soap box about evaluation research.

**Joseph Telfair:** Thank you again for the presenters. I agree with the rest of the panel that these are definitely worth -- projects that need further -- one of the things with Dr. Barnett's work. The background is really using that to set the stage really demonstrate find the point of view that you did have a decent and a good understanding of approaching this. I think the last point you made on your other slide with the CAMI in terms of actually a model. In terms of being able to agree with the previous commentary about being able to replicate this. The real challenge though is looking at rolling this out. Is there a way in terms of program design that can be replicated in the different settings?

The one point though that I think it was briefly touched on but I just want today make a point about it was it seemed to me from what you presented that the counselors themselves were actually the catalyst that made much of your program work. So you know looking at maybe profiling that characteristics of those or that panel an actually developing a, some level of measurement, some criteria for selection and measurement such that you would have a replicable model. A replicable assessment tool that would allow you to get as close as possible similar to that. In other words, a study within a study which is using your actual counselors an really looking at difference between their level of that or whatever effectiveness you want to use that you will see whether or not there's a need for statistic differences -- that seems to me that would enhance your work itself. The literature doesn't talk about that sort of thing. Even the way the health literature just generally covers that they were people training. It doesn't say measuring about the characteristics of those who are training an looking at ways we can be reply kited just be beyond here's a list. If we are moving into a more practice based evidence approach really being able to standardize that process and to be able to replicate that in such a way we can have that. I thought the cost effectiveness even though -- it's very good in the sense that we don't always consider beyond the study who else we need to speak to about this. Using that approach was good. With Dr. Key I looked at be on the same kind of outcomes you had this issue of differential outcomes and so I agree at differential outcomes are critical as well as the comprehensiveness. The program is critical. The question that I had was the question of being able to predict of this. The challenge really is that you take the approach that you are looking at multiple factors and that you can address as part of your program to have some degree of success with the young persons that you are dealing with. The challenge really is though that what is it? Is there a way to look at those characteristics again? Even though you do have a comparison and design a means by which you can be able to develop some kind of predictive model that will work for you given what you are trying to do. Your scientist may come up with that. Given that what you are talking about particularly around this area and challenging is it something that can be done? Also the question of those in terms of program and the level of -- I couldn't get a sense how much that you did. I would say that becomes critical. In overall I have a suggestion. We talk about evidence based work. I would suggest that you consider what it is that's done particularly in the field is practice based evidence and really the question is what is it? Do you have promising? Do you have merging sort of practices? Do you have promises at best? Those sorts of things. There's a set of literature that's best practice evidence. If you -- design and that sort of thing. The real question is how do you replicate and how do you apply this and what do you learn from what people have done. Practice based evidence focuses on a scientific model that allows you to ask the question what can you learn from what people have done an been able to move that from idea to a rigorous design to begin to look at outcomes that actually can be turned around back the other way an look at it from cost effective as well. Given the way you designed your project in particular that's an approach you should consider.

**Dr. Trina Anglin:** Thanks for wonderful presentations by our two presenters and three response panelists. At this time we are now open for a general discussion period. Again, like there's a microphone in the center of the room and there's a microphone on the far

right. And so and we have somebody who would like to ask a question. Can you please introduce yourself?

I'm a senior counsel with the women's national law center. I work on education and employment issue, particularly education for at risk girls and students pregnant and or parenting. My question is for Dr. Keys, one thing we hear a lot are child care and transportation are two critical services that girls need in order to stay in school. Does your program address those at all or did you offer that as part of the program or did you assist girl in finding child care how did that work?

**Janice Key:** That's a good point, child care and transportation effects all of us mothers doesn't it especially teenagers. We did not fund child care but we had a social worker who helped them find ABC vouchers after finding child care and we also helped girls recognize what quality child care is and being more discriminating in their child care. The high school that we were at was an urban high school where everybody could walk to school so transportation wasn't a problem. The health care services I provided say I was the pediatrician for both the children and the mother and the baby and that was not on site. That was at the university nearby because in South Carolina you cannot prescribe or dispense contraceptives on school property. So since I did not want to go to jail they came to the university and we did provide transportation for that if they needed it. We encouraged them to be independent and gradually become more independent. If they needed transportation we provided that.

Thanks. I have a follow up comment. I was very interested to see that 6% of the students were expelled and I just don't know if you have any information to shed light on that. I know there's a huge issue with discipline particularly of African-American girls and boys. African-American girls are the second highest or most disciplined group. I was curious about that. I was also curious about whether you would consider including in your in future data acceptance and enrollment rate in post-secondary programs, college job training or job placement. Because as we know now high school diploma is just the bare minimum that people need to live - earning wage they have to go further than that.

**Janice Key:** I don't have it with me but the expulsion rate and suspension rate for those girls were better than for the high school overall. It was 6% but that was pretty good for that school.

As far as following girls after high school and in future years we really did haven't the means in this study to find them again and record that anecdotally they all stay in touch with me there are a surprising number who go on especially community college which I think is the most economical way to go to school and onto some four year colleges.

Thank you so much for your work. This is really great.

**Dr. Trina Anlin:** We have a question to the right. Please enter introduce yourself?

I have done a lot of work in the area of teen pregnancy and -- I have a question for Dr. Key it's a concern you kind of glossed over this a little bit on one of the comments on your slides that talked about advantages or theoretical advantages that were reported in terms of early or teen childbearing in the African-American urban youth. Could you be more specific about that? I never come across anything in my research that would suggest that there's any advantages to early childbearing in any racial group.

I don't want to take the blame for that comment. That was actually from the reference from Dr. Geronimus. Looking at it, I think a very select group of women live anything chronic poverty in urban setting where their help went down as they got older, so she proposed that there may be an advantage to younger. It was very theoretical.

I didn't want anybody to leave this room thinking strong evidence to support any type of early childbearing being any kind of advantage. I wanted to bring that out. My concern is as I look at that comment. We hear a lot about teens and teen parents and the children and the cognitive developmental behavior, I can't recall problems. We don't hear about the specifics of those. I was wondering if anybody on the panel could address that question. What kind of behavioral cognitive issues?

I will take that they tend to be later in talking and have reading problems. If you do a school readiness they tend to be less ready for school. Of course as they get older they are more likely to start having school failure and drop out of school and the whole cycle to become a parent themselves. Even when they are little you can see they are not delayed necessarily but as a group behind in language and reading. That's why our program emphasizes literacy. We call it book day. So we encourage the girls to read a book a day and you have to model that because teens sometimes feel like it's silly to read to a baby. You have to show them appropriate developmental interaction with the baby.

I was wondering if Dr. Beers has any comments to add your program would also be able to address that question.

I echo everything Dr. Keys says. I would refer you to - there's the national campaign put out a great report a couple years back playing catch up children born to teen mothers. It's a comprehensive review of the literature looking at developmental outcomes for the children born to teen parents. It's actually a great reference. I would refer you to that as well if you are interested in further research.

Another question.

I'm Carol and I do training and consulting for adolescent sexual health. I had a question, comment. I keep thinking of Dr. Brindis' slide on further defining diversity, age, culture, ethnicity, sexual orientation, gender, disabilities these other subgroups. Can any of you address some of your findings as they relate to these other subgroups? I think it would very much benefit particularly in replication to know what the effects in some of these other communities?

What about if we ask each of the panelists to address that from his or her perspective because it's such an important question.

**Beth Barnett:** I can say something about age differences that we have observed in our program. It's been so much easier to engage the younger teens and keep them engaged for a long period of time. The older teens sometimes are already so much more involved in other kinds of high risk behaviors on the one hand. On the other hand sometimes it is more successful ones that are more engaged in school we have a harder time keeping them participating in the all the different components because they are so busy in a good and protective way. Those are some of the different side that is we see. With the younger teens we can get the support of their family members often to really help keep them engaged and participating.

**Janice Key:** I think for our group they were at this high school that was all African-American title one school all living in poverty there really wasn't the means to statistically look at those common differences that we look at. Right now I am engaged in a project, a community in school project in a rural community that's supported by the new morning foundation in South Carolina that involves secondary and primary prevention. We ran out of teen mothers. Now it's primary prevention. Now we have been there seven years I can see so many things I would like to measure and I forgotten who talked about the depth of the issues that teenagers are dealing with. It's just overwhelming. How to describe which one lives in poverty an which one has substance abusing parents and which one suffers abuse an all of these different things factor in to take care of an individual person. I wish someday we would have the resources to understand the influence of each one. I think it's a miracle that any of them survive. I don't really have that measured scientifically. I can tell you taking care of them as individuals, what they do; the social worker and I we get to know that person and scramble around for the resource that is she needs. I would like to be able to mesh that in a scientifically valid way but I can't right now.

**Lee Beers:** You know I think for us similarly we do have -- we have an African-American population. We like Beth have found that often our higher risk teens tend to engage better services. The reason that the higher functioning teens are really busy in school and work and doing all of those other things. There's another interesting question though and that's looking for outcomes for parenting. This is some literature that I looked at. It is very interesting because I think everyone has been reinforcing that and not every teen parent is the same. I think that is a really important point. There are some you know both clinically and research in the teen parent to really who are fabulous parents and others who really struggle how do we figure out who's going to struggle and have an easy time. I think looking at some of the things that cohesion in the family unit and conflict in the larger family, looking at things like the parenting qualities of teen parent. Her attachment to her own parents. All of these things have been at least in little glimmers shown to positively affect parenting and that in term you look at outcomes for the children, children of teen parents who had more positive paring do better. So I think it's really easy to look at it all in one big percentage. I think as we move forward we really do need to drill down on how do we did I have reinsulate and how do we figure out what are

the qualities of positive parents and how do we encourage those and what's the background infrastructure that helps support that. There's definitely is evidence that that really does make a difference.

**Dr. Trina Anglin:** I thought there was one more panelist. He escaped and is sitting at the table. What about if we have one final question. I think that's the only one left.

My name is Ann and I am working with a group called wider opportunities for women. Those of you who heard of WOW know that we work on economic security issues for low income, with low income women both at the policy and advocacy level. Here in Washington DC where we are based we are doing a very interesting by lot project around the intersection of poverty and teen pregnancy. We are looking primarily at it from the poverty perspective and we are working with three local reproductive health groups, Planned Parenthood and Mary center and healthy baby projects which are represented in the room. Our role is to integrate job readiness and career aspirations, issues into the teen outreach programs that each of these organizations runs very successfully. That's the background. My question is an implementation question. One of the issues and it's primarily for Dr. Barnet but other if you have ideas also. One of the issues that comes up with each of these teen groups is consistency of attendance sort of compliance and I am curious about how you got a regular participation in the CAMI interviews and got a large enough sample because one of the issues that we face is the as I said inconsistency of attendance an in and out of the program and you know are we going to have a critical core of participants from which we can gather reliable data?

**Beth Barnet:** So, I can say that there were definitely challenges to implementation and adherence with what we considered our minimal amount of CAMI delivering, but I think one of the core reasons why we were able to actually get about 75% of the CAMI home visiting group to participate at least to our minimum defined set of services was that we went to them. And the key feature was to really develop a relationship between the CAMI counselor and the individual teen. This was a relationship that was built over time. It was initiated and the outreach was going where the teen is. Meet the teens where they are. We addressed all sorts of barriers that would get in the way, so in order to sit down and do a CAMI session if there's no home you have to work on housing. If there's no electricity in the home and you can't plug in the computer you have to address those kinds of needs. So the three CAMI counselors did sort of multiple outreach and coordination of services, care management of service in order to get the teen ready and able to then say okay how am I going to focus on myself and my goals and my skills building and how am I going to think about my few future and reproductive child bear. We also had a male outreach program sum we were going to do CAMI's with male. That didn't work out so well. One of the key thing that is we learned was the young fathers were not at all ready to participate in any formal curricular activities until they had their very complicated and many needs met around they wanted a job. They want today get back into school. They needed legal services. On and on. So I think that well intentioned program people need to really understand the reality of where these teenagers' lives are. You can't just sort of plop yourselves down without addressing all the things these people need in their lives, the basic needs in order to look forward.

Okay. Thanks to our wonderful panel. That is Dr. Lee Beers a Dr. Florsheim and Dr. Beth Barnet and Janice Key and to our excellent responsive panelists Kristine Andrews, Sarah Avellar and Joseph Telfair can he have. And of course to everybody who's been a participant here. You have asked such wonderful thought provoking questions that everybody needs to have a round of applause. Here comes Reesa with instructions for lunch.

**Reesa Webb:** Thank you Trina for being such a great moderator.

*Applause.*

**Reesa:** we are now at lunchtime. We actually have instructions I'm sorry because the venue is pretty small, so if you could exit at this door to my right to get lunch and then come back in at the door to my left when you come back so that we do a roundabout. That would be wonderful. Also, similar to the washroom situation there are a lot of us and so there is going to be a line to grab your lunch, so for those of you who would like to wait an not stand in line feel free to visit with your colleagues at your table until the line dies down or if prefer to network. We will try and regroup with Pat just a few minutes earlier as long as everybody gets their lunch. Thanks.

We have been able to address the problems you are experiencing on the webcast. If you are still having problems if you close out of your window and reopen it, hopefully all will be well. For those in the room if you continue eating Pat tells me she doesn't mind. We are going to continue with our conference. We are very privileged to have Pat Paluzzi here to talk about policy. I want to introduce her formerly. Pat, as many of you know, is the President CEO of Healthy Teen Network. Her experience includes implementation and evaluation and international work and teaching at the graduate level. Through both her clinical and academic preparation she has gained a breadth and depth of the experience that shapes her strategic thinking regarding the field of adolescent health. She employs this thinking to guide Healthy Teen Network's work on behavioral issues as they effect teens and young families please help me welcome Pat.