

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**

Session Moderator: Trina Anglin, M.D., Ph.D. Lee Beers, M.D.

Thank you so much Claire. We are now going to move from the research that Claire so well articulated into putting the results of that research into practice and in order to do that I would like to invite the next panel to come and be seated up here and while they are doing that I would like to introduce to you the Dr. Trina Anglin. She's the Chief of the Adolescent Health Branch, Maternal and Child Health Bureau. We have two offices of adolescent health in the federal government. Dr. Anglin will introduce to you the panelists that will be talking to you. One thing I neglected to mention earlier to those of you in the room. You probably have seen that there are a couple of microphones set up. One over there and one over here so that if there are any questions or at the question and answer period we would ask you to use those microphones please especially since we are being webcast. It's important to use the microphone if you do have any questions.

Thank you very much. There's only one real office of Adolescent Health that's within the Assistant Secretary of Health. A long time ago our unit within the Health Services administration has that designation from a mandate from Congress now there's been a huge transition. There's only one office of adolescent health. Now we are back to being an adolescent health grant. Hopefully that clarifies the distinction. As Reesa said we are going to move to programs. The title of this panel based session is research to practice applied research approaches -- it's a two part panel discussion that's going to be exploring examples of effective and promising approaches -- programming and that this discussion is divided basically in two. We are going to have one hour with two panels and three respondents and then there's a break and -- so that the two domains are going to be discussed this first hour. I wanted to let you know that the Department of Health and Human Services and as far as I know from the private sector have not yet really defined in a broad way what criteria for defining evidence based programs. This is really -- at least the degree of precision and hopefully can happen in the future. Our presenters are going to be talking about findings from their own research and their own programs. Because we have a lot of information to cover we are going to be opening up this session for discussion basically questions from these presenters and response panelists only after everybody has spoken. Also we are running about 15 minutes late. If you would like to ask a question during the discussion period as you were just instructed that had you need to go to one of the floor microphones. There's one there in the middle of the room and there's one over there on the far right of the room and I don't see one on the left. That will be where the floor microphones are. If you can keep your questions pretty short. That

means that more people will get to ask their questions. For those of you who are participating all through the web cast please type in your questions and the chat box on the screen and that -- we will try to fold them in as people who are asking their questions from the microphones. We will have a tradeoff there. So that today you know like as you just heard a wonderful presentation by Claire we also have a lot of really, really wonderful presenters. We are going to be sharing their knowledge and perspective with you. It's my delight to be able to briefly introduce each of them. I am only going to have time to say one or two sentences. However, in the center you know the old book here is that you can read fairly excessive biographical sketches for each of the presenters. Our first presenter is Lee Beers. -- Healthy Outcomes for Mothers and Babies. She's assistant professor for pediatrics at George Washington medical center here in Washington DC. She's the director of Healthy Generations program, a teen -- comprehensive medical care and case management and that's care management of mothers and their children and services to adolescent parents and their children. Before we welcome Dr. Beers to the podium. I wanted to ask you to be really active listeners. I am going to read to you the questions that we have asked our response panelists to respond to. I could like each of you to be thinking about how the presenters are achieving these sorts of areas, so one what is evidence based intervention and should we have clearly defined a unifying definition as concerns this field of adolescent pregnancy and participating. What makes each presenter promises and what's missing, kind of what is it that we all need to do and finally what are the considerations or challenges relate today the particular domains. You might want to think of cultural issues, family relationships, and attitudes. There's a very, very big list we need to consider including some of the areas that Claire had mentioned. Without further ado I would like to introduce Dr. Lee Beers.

Lee Beers, M.D.: Wonderful thank you everybody. Thanks for having me here today. I am not going to talk about birth outcomes but postpartum birth outcomes for mothers and children. I am a pediatrician so this is something that I do every day. This is something near and dear to my heart. I am really pleased that I have the opportunity to talk about it today. So if you don't remember anything else from my talk today I hope that you remember this one slide. Adolescent mothers and their children are at risk, I want to emphasize the "at risk" part for a number of negative health outcomes but with appropriate support most can be healthy and successful. I do also want to know that we can't forget about the health of fathers as well. Unfortunately there's not a lot of literature for looking at the health of fathers. I am going to focus on maternal outcomes. We always hear about the risk. As professionals we talk less about the -- I think we can all agree that regardless of what has happened up to this point once a teen is pregnant and delivering a baby we want that family to be healthy and successful. This is really important the literature in this area is spotty. Many studies have significant methodological flaws. Overall I think we need to improve program evaluation. However the literature available does suggest that things that professional and policy makers can make an important difference in a variety of areas. I think it's important to emphasize that it's vulnerable and overlooked population. It's important to put attention on the population and they deserve our resources. As I mentioned my talk today is focused on nonproductive outcomes. You are going to hear about repeat births later today. I think it's important to remember that

positive health outcomes are really important on the overall success of the families. If a teen delivers a baby prematurely that baby is at risk for specific morbid mortality which then leads to other negative outcomes. If a child is not up to date on his shots he can't be in school if he can't be in school or day care it makes it difficult for the teen parent to be in school or day care. It's preventable and negative outcomes. Again, I want to emphasize that even with very basic supports adolescent families can really be helping you be successful. Adolescent mothers and -- anemia, poor weight gain, increased mortality and premature delivery. Adolescent parents are often at risk both during and after pregnancy for depression which compared to all ages can have significant impact on -- what the literature is not clear is the relative influence of maternal age on the poor outcomes as opposed to environmental influences. For the 14 and younger and very young their biological factors do have an influence. I think regardless of cause, adolescent mothers are at risk. That's something we need to be alerted too. Children born to adolescent mothers are at risk. Here again the -- I think the effects of maternal age are a little better established here. Maturity can lead to problems. Developmental and behavioral problems and late effects increased rates of substance abuse an early sexual activity after increased likelihood of adolescent parenthood for the children themselves. There are differently studies that increased use to child abuse -- there's particularly true as other stresses such as family conflict or poor educational achievement. So you know given the fact that we all sort of talked about how the literature it's a little spotty in this area. Where do we go from here? Obviously it's important to continue to evaluate our programs and the methodologically sound way. We want to better define behavior risks and outcomes for our participants. That's a long way away. We have adolescent families here now who observe and need our service. When I -- I think it's useful to look at what's there and take an assessment of what we know and build on that. So when I first began doing this wrong. One of the things I did -- the American academy of pediatrics on the care of adolescent care and their children which was very helpful to me. The policy statement was developed on the review of the literature. So while the policy statement was sort of intended for medical providers I think there are a lot of things in it very applicable. If you have the highlights on statement that they should create a comprehensive home. This should include inclusion of fathers and other family members. We should adapt our counseling on the developmental level of the adolescent who are still developing their logical thought. It's an important to remember this. Encourage positive parents to the adolescent. Emphasizing what the teen is doing well and not always telling them what they are not doing well. Also teaching child development so that the teen knows and understands what to expect from their own child. There's intervenes that suggest that interventions to improve parenting can be effective in this population. Closely monitor the developmental progress for the teen and child for the risk do exist. Encourage positive involvement of the standard family and partner and the baby's father. As everyone will talk about social support is very important. It's most beneficial if it's affirming and positive but still giving the teen the opportunity to be a parent and giving them the opportunity to do some parenting on their own. Encourage positive involvement of extended families and partners. Provide planning counseling to help prevent unintended and encourage education in order to improve long term success. The next thing I did was I drilled down a little bit more in the literature ran looked at what some of the more promising -- this isn't to say there aren't really a will the of great models out there but

there is a few high lights. None of these programs are adequately -- I think that these are some program that is have good evidence behind them. It's also worth mentioning that health outcomes as I'm talking about today are almost never the primary outcome of the interest. The primary outcome is almost repeat pregnancy or educational attainment. Those are obviously very important. Many of the studies do include other health outcomes. I pulled some of those things out to discuss, so I sort of see several main categories in intervention including school based programs and community based programs and medical-clinic based programs. First is an example of a school based intervention. School based health clinics do help in improving the population. There's a literature review in 2008 that concludes that school based health clinics had a variety of services could relieve negative outcomes of adolescent parenting. System of the studies demonstrated successes and improved immunization. Theoretically I think this makes lot of sense. It's definitely an area that deserves more focus. This is one definitely good example of a promising practice or promising intervention. There are a lot of programs that are based in in the community and not every program can be in the school. I think there is an area where there isn't information about health -- there was a study in 2006 that looked at birth rates and I have teens who participated in a statewide program called the adolescent program. They compared the teens with the same number of pregnant and parents adolescents that did not participate in the program. They got three main services: meeting with a provider to develop a care plan, to assess and define their goals for the future and case management and peer group support and those meetings were at least once a month. After controlling the -- there were differences between the groups they did find that participants in the APP programs were more likely to have full term births and to have baby was normal birth weight. There were definitely differences between the groups there were definitely different. There were definitely thing that is participants in the APP program did better with. So I think it does suggest that this kind of program can really improve birth outcomes and encouragingly on a statewide basis, so the last thing is an example of a medically based program. I am going to focus for a few minutes on the teen tot program. They are generally located within a medical clinic and provide comprehensive primary care for adolescent parents and their children. Development mental screening and legal services and important they are provided in a single setting. They typically focus on access to health care and prevention over repeat pregnancy and social support an education. As I mentioned before the studies looking at this model are limited and varying in quality. Two reviews looking at the literature about teen tot programs. The program includes a number of positive outcomes an improved immunization rates this is found consistently across studies. Healthy weight for infants and increased number of prenatal visits they did provide increased contraceptive use and in some programs as well. I am not talking about that today. I am going to give you a real life example and highlight a -- our program is healthy generation programs. It began in 1995. I took over as director in 2003. It's located within a handful of pediatric clinics in Washington DC. We provide services to adolescent and their children. Provides comprehensive immediate CALL care acute care, reproductive health care and an access to wide variety an social and case management support an home community an school visits in order to better engage community and support systems and parenting groups and select local schools. We offer mental health services for mothers and fathers. We have male and female trained -- we serve about 450-500 families a year until they turn 21. We

have been grantees for over -- it has been a real key and critical program to our key and success. We conducted an evaluation of an enhanced service of our teen tot services -- we compared them with our routine services which were pretty substantial so here first are some baseline characteristics before intervention. I should note up until very recently our program provided predominantly post -- this information was conducted after the birth of the baby typically the baby was about three mops of age. So at -- interview the teen was average age was 17 the majority was in school or graduated over a third had repeat add grade.

There was a lot of preexisting academic. The average age of sexual encounter was 14. What we did for all the teen who is had reached we are still collecting 24 month follow up data. So what I would like to do actually pull out a health indicators for teens who participated in both armed of our programs and teen tot an intervention arm program plus some extra services. Of the 117 mothers that reached the follow up point we reviewed all of their records and there were four participants we excluded from the review. We knew they had transferred out of the state. We couldn't get their records. For everyone else we couldn't find the record we assumed they were up to date. For the-you will notice the difference between the teens and kids were different. There were a couple of sets of twins so there were more babies than mom. For the children we -- encompasses a full series of vaccines. Using this benchmark over 90% was up to date on their shots at 24 months. This is compared to 75% at age and the 75% uses a less restrictive benchmark. You did pretty well there. So for the adolescent mothers again, over 90% reported at least one well visit by the time they reached the 24 month mark. Most of our participants get their medical care directly for us. For insurance reasons some get their medical care elsewhere. We follow the family and track their provision and receipt of services. Of those 91%-70% had documented an exam and the other 30% -- looking at a number of different bench marks at the -- so I think these are pretty important outcomes and as we are serving the group that traditionally has difficult access to care and care leads to better overall health. In summary based on literature and own experience teen tot programs one of the promising practices. There's preliminary data that suggests it's effective and it's easily integrated into existing health care settings. There's more research needed improved comparison groups and better specific descriptions of services and closer look at outcomes and a look at the cost benefit. I would like to know that we have some funding from HR S A to do the exact evaluation. We are really interested to see what comes with that and we are interested to hear what's coming out of the field elsewhere.

Thank you.

Applause.

Thank you very much. I will introduce our next speaker Paul Florsheim. Dr. Florsheim is an Associate Director and Chair at The School of Public Health in Milwaukee. He's an adjunct Associate Professor and an Associate Professor of Social Work, School of Psychology and the School of Social Work at the University of Utah. He's a licensed clinical psychologist. Thank you Dr. Florsheim. I am letting them know how much time they have left when I hold up these little cards.

Paul Florsheim, Ph.D.: Thank you. Thank you for the introduction and thank you for being here and I am going to be speaking about healthy relationships and the engagement with adolescent fathers. I want to start by acknowledging both, I have too many collaborators and too many students to put onto a slide, but this is work that I have been doing for a long time and so it's hard for me to thank everybody. I want to make sort of a special thank you for the participants who have been in our studies over the years and of course to the funding agencies that made this work possible both the Adolescent Family Life Program and the National Institute of Health. I want to start with this question of are teen fathers relevant? Are they relevant to the wellbeing of the young mothers; are they relevant to the wellbeing of their children? One of the things if you look in the literature there's good evidence that and growing evidence that positive paternal engagement is associated with positive child outcomes. I feel that's an important point to make. When I give an example of the national early head start study. Positive maternal involvement is associated with and predicted on improved language development and improved emotion regulation and improved cognitive functions in children up through their early childhood years. It's also the case a very important point to make is that positive that the corollary to this finding is that positive coparenting engagement is predictive of positive paternal engagement. The negative to that is problematic parent relationships is also predictive of negative maternal engagement. Is this, a lot of this research or much of this research comes from the adult literature on coparent and parenting? Is it true of teen parents as well? The answer from our research study is it's no less true of teen fathers than it is of adult fathers. So the issue with teen fathers is that they are at risk for a number of problems related to personal engagement and coparenting involvement. They are more likely to drop out of school and more likely to get in trouble with the law. They are more likely to use substances or et cetera. That these problems make them less likely to engage in positive coparenting and less likely to engage in positive parenting. To add to the problem they are more difficult to recruit and engage in programs, so the question that often is raised when we are talking about young fathers is well, do we try to help them or do we write them off. Are they too much trouble or are they worth the effort? My answer to this and a number of you are doing is that we have been writing them off for too long. One of the questions is if we are going to include these young fathers in the lives of their children and in the lives of the young mother when do we do that? How and when do we do that? How do we engage and when do we engage them? Currently there are no very clear answers to this question and that more research is needed to be done in order to understand this. One of the things that many program haves tried to do is to recruit young fathers after the birth of their baby and the problem with this although; I think that there's good reasons to do this. The problem with this kind of prevention or universal perspective is that many of them have already disengaged or many of them are so BUSY trying to function as fathers that they really have very little time for a program. As I said their program, the young fathers, expectant fathers tend to be program aversive in the first place. I have become an advocate of engaging fathers as early as possible and through the partner's prenatal clinic. So the next question is how to include fathers? And there's been some research on how to effectively include young fathers? It focuses on job training and parents. These are very sound ideas. It makes a lot of sense to do this. However one of the problems with this as I suggested is that we don't have enough research and others have mentioned this to really know how to make these programs work which is one of the

things that the adolescent family life program has done is really focused quite a bit on these young fathers on how to develop programs to make these fathers more engaged. What we have done at the university of Utah starting at the university of Utah and now Wisconsin Milwaukee is to focus the ray tension on getting the fathers early and to work with them through the co-parenting relationship and to work with them that the co-parenting relationship may be able to facilitate positive parenting and if they get more engaged in their relationship with their partner and with their baby that they will be more motivated to stay actively involved and the work force and stay in school we developed a program that's a co-parenting counseling program that focuses a lot on the relational skill that is will help these young men become positive engaged with their partners whether or not they stay together in a romantic relationship. There are different sets of skills that need to be tailored for different types of couples. Some we draw heavily on the marital literature to have a positive relationship and some we draw heavily on divorce literature which is an adaptive to how do you work in coparenting relationship when that relationship isn't necessarily relationship you want to stick with as a romantic liaison. Strategically we feel focusing on this coparenting relationship before the baby is born and we deliver many of these services before the child is born so we would allow the fathers to engage with us. There's a window of opportunity to engage in these young men wild the honey moon period is still on and the hope they will be able to engage in their child's life, so we make use of this prenatal phase. This next slide is a little bit difficult to see. -- We recruit prenatally - before the babies are born so we randomize a treatment group and control group. The treatment group gets services. The controlled group gets services as usual which usually means not much for these young men. We follow up after the baby's born an 18 months after the baby is born to see what these program effects are with interviews and questionnaires and with come video tape interaction data. What we are particularly interested in is whether the program is having an effect on this ideal of relational confidence and in particular. What you see if you look at the red in this is that the program seems to be having a more dramatic effect on the parenting and the coparenting behavior of the young father than of the young mother at least at 18 months down the road. So, in what you also see if you look at the bottom. Is even though the program long term effects or the short term effects appear to be with the young mother's relational confidence. One of the things I want to first point out if you look at the recruitment and attention data is that we, we are being fairly successful in our recruitment of the eligible fathers we are recruiting this is both, this is particularly to a study that we did in Salt Lake City. It's consistent with studies we have done in other locations. The recruitment it's about 59 to 60% of young fathers who are eligible to be in our study is participating. We could do better. Many of these fathers are already disengaged. We are looking for ways to include that. More importantly once we engage these fathers in our programs about 79% are sticking around for what we consider sort of the appropriate dose of -- as I mentioned before the program at this point appears to be having a more positive impact on the young father than on the young mother. However what's really interesting to us is that the positive effects on the father appear to be mediated through the positive effects on the young mother to improve relationship and confidence. It's a complicated dynamic process we are seeing. This I want to emphasize includes young fathers and young mothers who are in a romantic relationship and also not in a romantic relationship. The next steps are to adapt it. To different social and cultural context which

is what we are doing. We developed this in Salt Lake City and now we are working on how this is going to work in a very different environment. It's largely African-American with there are serious poverty issue in Milwaukee that require us to rethink our approach to some extent, to compare our model and we are not doing this currently. We are interested in comparing our model to other models we have a couples approach but there's a very solid group approaches as well as job training focus approaches that we are interested in seeing. What if we focus on a different set of skills? What works better? And then one of the things that we are, while it's interesting to see that our programs are effective for young fathers more so than mothers. It is helpful that we want them. We want these coparenting programs to reduce stress. Stress has clearly been maternal stress has been clearly linked to unhealthy think outcomes. We like to believe that a coparenting counseling maybe effective in helping young mothers deliver healthier babies an adjusting to the transition of parenthood as best as they can in the early phases an in the later phases of parenting. So that concludes my slides. I want to just make reference to a host of research papers that have informed this area over the years and emphasize how important it is to continue to do research with these young fathers as well as the young couples themselves. I want to mention one of the ways in which I got interested in this study of young couples is that I really started with young fathers and learned very early on in my career that the way to find young fathers was through the young couples. It was only through a period of really sort of using the pregnant teen as our avenue to get to the fathers. They are very interested in the relationship between them. I feel as though in large measure the relationship between them is a critical piece of the puzzle in understanding how they transition in parenthood. Thank you very much.

Dr. Trina Anglin: Dr. Sarah Avellar siting to Telfair's right. She's a senior researcher with Mathematica Policy Research. Her research interest includes early childhood education and family support. Currently she's the co-principal -- evidence of effectiveness review. This project has conducted thorough and transparent review of the home visiting research literature and has provided guidance to states as they have developed and start to implement the programs that they are developing for home visitation which is a brand new and very large program with the Department of Health and Human Services. Our third esteemed panelist is Kristine Andrews. She's research scientist with child trends right here in Washington DC. Dr. Andrews has substantive experience in teen programs and qualitative research methods and as well as program evaluation. She is also the lead author on Child Trends' second chance homes report which details a promising set of approaches for adolescent mothers and their children including parenting support and educational assistant. Dr. Telfair you are on now. Thank you.

Joseph Telfair: Good morning everyone. Thank you very much for the opportunity to comment on this. I will try to keep my comments short. Because there's a little bit more that's going to be said. Primarily I was asked to look at the assessment side of what it is that both of you do in trying to do my best to derive that from my slides if I can. I think that looking at the focus particularly for you Dr. Beers one of the challenging issues and you touched on this and I want to just add a little bit more to that is actually operationally

defining what a healthy couple is. That continues to be a major issue. It's not so much as to the individual health outcome itself but it multiple -- you are looking at both social and cultural things. The question becomes in a study like yours the total study is that looking at those and beginning to define those and then work with whoever it is that is in a different environment the parent or the parent of the parent or the co-parenting issues that you touched on Dr. Florsheim. I wrote a note to myself. I didn't know if you considered this much of how much inclusion. You did mention this of the adolescent fathers and again focusing on looking to better operationalize their role. Not just indicating what the role is but also how do you actually measure that an look at that not just at one point in time but taking more of a life course assessment model to look at that as well. That becomes that. You need sound evaluation and to look at outcomes. I would acknowledge that this does take time and suggest that one of the things that you may want to consider when you look at this is we have a tendency to sort of write what we think or the ideal models to the programs. I would suggest to you one of the things to look at that the design is more realistic to the setting that you have. You have a comparative model as it is right now and you are looking at both the treatment and your control group. You are stepping back again and say what is realistic about the group itself. The reason I bring this up as you pointed out in the literature the challenges always replication of these things. We design a lot of nice models. The next person comes in line with this and does not always have the opportunity to do that. My last comment for you is that I think that theory is very much important. I would like at the mixed method design that allows you to look at the medical side of it and the other parts of it with your colleagues. I have a little bit more of that but I think the time is -- I would also suggest that the evidence building part of it is looking at the economy. Dr. Florsheim I think that the topic itself is an excellent topic that you have. It's very, very critical. The challenge of the father part is back into the same thing about what have you learned in terms of what's realistic given the environment that you have. Looking at what adjustment DOS you really need to make to make it applicable to your current environment? I would suggest that one of the things that you are not going to find that even though populations are different a lot of same issues are different. I agree that the innovation is actually going to be, being able to look at these over time sum look at the relationship over time. I think your innovation of asking the question of whether or not the father can be and how can the father be involve from the very beginning of the relationship and how that's changed. The other part of it is taking more of the ecological view which you begin to take and see that you may need to look at skills, because reality is and this is where I think a key piece of this is where does the break occur? Where does the break occur in the fact that where the father is a part of the co-parenting relationship but at some point may or may not continue with that and go onto something else. When that break happens what happens in that? The idea that you build skills for them to be able to have, to do this, to do the work in the department relationship as well as they decide not to continue to do something else is really from all the thing that is I read and also from the things I have done it's pretty innovative. I would say that maybe an avenue that you may want to look at particularly when they are walking in your path. The next thing I can have on that part I wasn't clear from the presentation that and this is an intake question. Your level of assessment that you have related to the perception of the roles that the young persons have. Do you look at this from the point of view of more what they bring to the relationship and in what can be

enhanced? Or do you look at what can be done with them? In other words more of an asset assessment. It seems to me if you take an asset assessment and you model the ground work. That will -- you are asking the question both for the parent and for the young person is what do you bring to the table. Given that what can be enhanced that you continue from. Just like any type of relationship or any type of things but look at it from the point of view what studies have shown about asset? That's a couple more comments. I have more but I will pass it on.

Sarah Avellar: Good morning. So I come from a program evaluation perspective. I am going to get on my soap box and talk about the importance of having a comparison group to determine why out would have happened. You need a group to compare it too. Having a very similar comparison group is paramount. If the groups aren't similar at the beginning you don't know the difference or the similarity to the program. It sounds like Dr. Beers, your results were preliminary you gave the example of the comparison of all two years in DC that's including parents who are not teen mothers and other things which I recognized. Randomized control trials are one of the strongest designs for determining the salt of the program. I am pleased the work is being done. Dr. Beers work indicates it's not necessarily your control group has to be no treatment. That's a contradictory term that when we are doing control groups partly with high risk population that you are withholding treatment. That doesn't have to be the case, you can offer an alternative treatment and see if your more intensive treatment has an -- of course the closer the more similar the two intervenes are between your treatment group and your comparison group the harder it is to discern in the fact. I think both of these examples are very nice and that they have a very lengthy follow up. I think Dr. Beers was 24 months and Dr. Florsheim was 18 months. That's long term change is very hard. So it's important to look down the line and see are these effects lasting? It's also important to look at the follow ups relative to the program? Do these outcomes last beyond the intervention? It's a very high bard but I think that's usually the intention. You want this change to continue over time? I think one thing to keep in mind is that I believe this was mentioned earlier. There's not ever going to be a one size fits all program, one program is not going to work for everyone? It's helpful to think what works and for whom? Dr. Florsheim mentioned it had difficulty of the program. Most programs and particularly with programs that are receiving low income fathers. It's helpful to think about who's in the program because those might be more motivated fathers and more likely to be involved with the mothers of the children and maybe the program is effective for those fathers. That's not a limitation of the program it's useful to take into consideration if you are implementing a program and thinking about whom will this program help?

Kristine Andrews: I am happy to be part of this panel this morning. A benefit of going third is a lot of things have already been said. I think I want to begin by saying overall we know there's evidence of rigorous evidence out there in pregnancy prevention programs particularly looking at fathers and I think that the two programs that were described here today are both great examples. Where right now we are in a great time in this administration where science based research is really being push odd the forefront. We are looking for outcomes. We want to see what programs are working and why? And trying to assess what are the components and what is it about those program that is make

it work and how can we figure out what, how, what populations they are working for so you can think about how to be, keep fidelity to the model but think about adapting it to the community. There's a host of programs around at this point that fit different size communities and different size budgets. Speaking specifically to our two presenters I think that I was really pleased with Dr. Beers focus on what I think is more of a positive development. I am in development in Child Trends. We are doing so much research on deficits. It's great to take on a street based approach and look at healthy relationships and how do you define that and build research about what do healthy relationships look like? I think that, I agreed with the first respondent about maybe encouraging the study to move toward a mixed method approach including science you had in your background. In Dr. Florsheim's program I am excited that you are looking to highlight the importance of father involvement. I think so often fathers are looked at for their financial contribution they can make but they really have value beyond that to add to the success of that parenting relationship and one other point that I really that really resonated for me is looking at the relationship dynamics. I do a lot of qualitative work and we have done many studies that are looking at that partnership and how the male in that relationship plays a big influence on the contraceptive decisions of the female. Not ignoring that there are really specific components to the relationship of the teen mom and dad that need to be explored further, so thank you.

Dr. Trina Anglin: Thanks for the very astute comments from our panelists. I think our presenters were busy taking notes from the wonderful suggestions they received. We are running late, but we do have a few minutes for people who would like to ask questions. Please step up to one of the two microphones and for people who are participating in this conference through the video please type in your questions in the chat box on your screen and they will be delivered up here so that your questions can also be addressed. Does anybody here have any questions?

Good morning.

Can you please say your name and where you are from? That will help everybody.

I'm Marie. I'm from mobile Alabama. We work with the healthy start program. You spoke about the recruitment. I would like to know if you could share ideas on what your program did to help recruit the fathers. I am relatively new to the program. It seems we have a hard time engaging the fathers in participation of the program. I would like you to share some of your ideas on what your program did to recruit the fathers. Seventy-nine% of those was really good. I want to get to know what you did for the recruitment process and how did you help maintain to participants to remain in the program.

Dr. Florsheim: I think there are a couple things about recruitment. I will mention the key one of the things I mentioned was I did sort of puzzle with this idea of how do you get, if you are just looking at the fathers it took me awhile to figure out in order to have the representative sample of fathers who were maybe on the fence might not be around after the baby is born is to rely on the pregnant teenager to recruit. It's early on and many are at that point, I think that I would go so far to say most young fathers are at during the

pregnancy really want to do well and so they are more open to the possibility of being involved in a program. You also have the leverage of the pregnant teenager. She often has substantial leverage or the biological mother to get them there. That was sort of the approach that I sort of happened upon or thought through early on has worked. Nothing else has worked. I tried other things. Going through the pregnant teenagers has worked more effectively than other approaches. The other thing is we pay them for their research participation. That helps a lot. I think we would have a very different sample if we didn't pay the pregnant teen and the young father to participate in the research and all of them are participating in the research even if they are not in the program. I don't think that necessarily keeps them engaged. There's a third component. We work really hard developing a relationship with them and maintaining that relationship over time. Everyone from the person who's first speaking to them to the person who is speaking to their parents about parental permission, to the research assistance, to the providers, everyone is trained to recognize that we, this is a long term relationship that we want to maintain and it's very important that they feel appreciated and respect. So those I think are the three components.

Somebody who wants to ask the question?

Good morning. I am Jo Anne from Freeport, Maine. Also a question for you Dr. Florsheim. I am wondering if you have documentation.

I do. There are core factors. We have developed so there's a number of measures that we have used for relationship competence group kind of broadly defined. One of the things that we focused on mostly is a coding system that we have developed and that we have thought through in terms of I mean there's a lot of different ways about relational confidence and healthy relationships and adolescents often text. We narrowed that down what are those aspects of the co-parenting relationship. The co-participating relationship that's going to be the best predictor of maternal and paternal involvements. A lot of it is focusing on the warm and acceptance. A lot of positive aspects of these relationships, the strength based approach as well as empathy and commitment, so the commitment to the relationship but commitment to the process of being a co-parent. We ask a lot of questions and then we code them using this coding scheme. So far that coding scheme has worked pretty well for us in terms of predicting whether the father remains involved or not. It's also as we quickly mentioned. We define it individually relationship confidence. We are interested in teasing apart the relation confidence and the fathers' relational confidence.

Dr.Trina Anglin: I was going to end this part of the panel now.

This young lady was waiting. I just want to allow her one moment.

I won't even ask a question. This was going to be a question for Dr. Florsheim. I'm from Senator Hatch's office. I just want to compliment you on your work. And everyone's work in the room. It's a difficult area of research to do. It looks like you are all doing phenomenal things. Thank you for your work in Utah.

I want to mention Senator Hatch wrote the legislation that funded the adolescent family life in 1981 I believe. So we are all indebted to his efforts as well.

Dr. Trina Anglin: So thanks to our wonderful panels, to Dr. Beers and Dr. Florsheim and to our three expert respondents. This is the end of the first part of the panel. After our break and we will try to, if we come back say at ten minutes after 11 that will give us ten minutes you know to grab a cup of coffee or to use the facilities and then we will come back to the second part of our panel and we will be hearing astute comments from our three respondents as well.

Thank you very much.

Applause.