DR. PATRICIA PALUZZI

MS. EVELYN KAPPELER: At this point, I'd like to introduce Pat Paluzzi. She's going to be talking to us about evidence based programs and approaches that support pregnant and parenting teens. You're going to hear this theme throughout the next two-and-a-half days, our commitment to using evidence based policies and programs in the work we do.

Pat's been active in the field of reproductive and maternal and child health for over thirty years as a clinician, a researcher, administrator and advocate. She came to the Healthy Teen Network in 2003. And during that time, the organization has grown to twice the number of staff. Before joining the Healthy Teen Network, Dr. Paluzzi worked for the Baltimore City Health Department as the Bureau Chief of Adolescent and Reproductive Health, ran a nationwide education project focused on changing the paradigm of care for survivors of intimate partner violence, was part of a multidisciplinary team working with pregnant substance abuse women, and provided a full scope of clinical services to young families.

She's a certified nurse midwife with both a master's and doctorate in public health from the Johns Hopkins Bloomberg

School of Public Health in Baltimore, Maryland. And we look forward to hearing from her with regard to evidence-based programming and the work we do. [applause]

DR. PATRICIA PALUZZI: Good morning, everyone. So, first of all, I just want to thank Evelyn and the Office of Adolescent Health for having me come and speak with you today about what we know about evidence-based programs and approaches that support pregnant and parenting teens. We're really excited to be here. I don't have to read this disclaimer, but you have to note this disclaimer. Everything I say is my words. They're my words. They are not the Office of Adolescent Health's words or JBS' words or anybody else's words for that matter.

I'm the President and CEO of Health and Teen Network, as Evelyn mentioned. And just for those of you who may not know who Healthy Teen Network is, we are the only national organization that focuses on both the prevention of teen pregnancy as well as supporting the pregnant and parenting teen.

I have to say: hearing Dr. Jones say that that's what they believe, it was really heartening. Because it's a hard

sell sometimes; how do you say that you support primary prevention, but also support pregnant and parenting teens? Because think you're kind of talking out of both sides of your mouth. So it's really nice to hear those words spoken at the national federal level. I think it's a really exciting time in our field because we actually do have an administration that seems to get this. And so, good for you for being able to do some really good work during a really positive moment.

So our mission in our organization is to build capacity among professionals and organizations like yourselves, through education, advocacy and networking-- so that you can assist adolescents and young adults, including teen parents, to have access to the services and education that allow them to make responsible choices about child bearing and family formation and be supported and empowered to lead healthy sexual and reproductive lives.

The objectives of my talk for today are: by the end, I hope that you will all learn about available evidence for pregnant and parenting teen programs. And I started in 1996 and came up-- it's not really to the present; 2009 is the last resource that I will refer to. That you will

understand what that evidence says about what does work, that you will learn about using evidence-based principles to develop programs-- because, as you'll hear, and as I'm sure you're aware, there are not a lot of proven-effective models for working with pregnant and parenting teens. That you will learn about a comprehensive logic model that we have developed that will help guide you thinking through how to support pregnant and parenting teens. And we'll talk a couple of minutes just about what is effective adaptation.

So the talk is sort of divided into kind of three areas. First, I'm going to go through some of the key literature as I see it. I'm going to start with some recommendations that were put forth by the Center of Assessment and Policy Development in 1996 for working with this population. I'm going to talk about some evaluations that were printed by the Future of Children in 1999. I'm going to talk about what Lorraine Klerman found in her report, "Another Chance Reducing Subsequent Birth to Teens." I'm going to match that up a little bit to a literature review that we conducted in 2007. And then I'm also going to mention "Advocates for Youth, Science and Success" 2009 publication.

I'll try and summarize that for you a little bit about what do all those things say about what actually matters? And where that sort of leaves us in the field. In terms of those resources, you'll see that I brought Klerman's book for you. That the "Science and Success" book from Advocates will be here before this conference is over, maybe today, maybe tomorrow. But it's coming so you'll have that as well. And I've footnoted the websites where you can find the other resources that I'm going to use. And I brought just a couple of the order forms for the "Future of Children" report and a couple of a Mathematica report that I'm going to refer to.

So the Center for Assessment and Policy Development are some of the first folks who put out some of what I would consider the more comprehensive look at how to support pregnant and parenting teens, because they looked at sort of three domains. They looked at the importance of supporting the pregnant and parenting teens and their children in terms of their self-sufficiency. They looked at them in terms of the healthy outcomes for the children and also family outcomes. And they delineated these. And I would say that we have used this work a lot in our

models. You'll see that they frame the BDI logic model that we've developed that you'll see towards the end of this talk.

So basically, when they articulated these needs, they said that for self-sufficiency outcomes, programs should look at increasing school attendance, increasing progress towards school completion, increasing graduation from high school with a diploma as opposed to a GED-- we know diploma grads do better with more successful movement from school to further education and training or employment, and I think that's even more critical in today's economy, that you're very limited even with a high school education as to what kind of living you can make in the United States today-- and then increasing the length of time between the first and second pregnancy.

When they looked at what developmental outcomes programs should target for the children of adolescent parents, they said they should have increased healthy births, increased age-appropriate physical, emotional, cognitive and social development, should be more school ready and should receive all of their appropriate health and child development services on time.

And finally, in their outcomes for families, they looked at increasing the practice of good parenting skills, including the ability to obtain needed services for one's children and to provide developmentally appropriate nurturing and stimulation, to reduce the use of inappropriate discipline, and to reduce an incidence of child abuse or neglect and domestic violence. It seems like this... How many of you are working with the domestic violence piece, the intimate partner violence piece? A number of you. Okay. So this is probably a good frame for you to spend a minute with. Since it is broad based and does sort of look at all of these different outcomes.

Further, CAPD were really good proponents of school-based programs. How many of you are going to be working within schools? Okay. And how many in communities, community based settings? And about how many are in a clinic or hospital based setting? None. Okay. And what about homes, home visiting? So it's about a third, a third, a third. And some duplication. It looks like some of the same hands went up. So multi-site settings. Okay. Well, that's great. By the time I'm through, I'll touch on some

evaluations for all of those settings. So I hope that will be helpful.

But CAPD was particularly supportive of school-based settings, and I think part of that is because they did have such a broad, comprehensive look at the supports that are necessary and put a lot of emphasis on education. And they really felt that school-based settings provided a better opportunity for early intervention before a teen drops out. They felt that the research showed that the interventions after the receipt of welfare were less effective. So once a teen sort of drops out and starts down that road, it’s a little harder to prevent subsequent births and kind of get her off that road.

CAPD thought that providing services onsite might in fact achieve more positive outcomes than those who did not provide services in schools. And they base some of this on this research in Ohio's Learning, Earning and Parenting Program -- the LEAP program -- that suggested that efforts in the State of Ohio aimed at increasing the attendance and retention of teen parents were most effective when child care and case management services were provided onsite.

They further went on then to develop a set of guidelines for quality and best practice for school based programs for adolescent teens and their children. They said that in order for a program to be truly comprehensive and supportive, it should provide child care. Prenatal care, reproductive health services: if not onsite, certainly a good link…preventive health care for children similarly with a solid link. Parenting education, case management family support, flexibility, quality educational programming and father involvement. And I would think that we would agree that all of these still hold true today even though it's now fifteen years later. Hard to believe.

So moving from what CAPD said in 1996, Future of Children did an evaluation of six home visiting programs. In 1999, the report came out. And again, you can get that at the futureofchildren.org website. They looked at the following six programs. Hawaii's Healthy Start which served families through screening at birth as highly stressed or at-risk for child abuse. The Healthy Families America program, a child abuse prevention program that evolved from Hawaii's Healthy Start and is now the subject of a pioneering multi-site research network... the present voice being in 1999.

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The Nurse Home Visiting program, a university based demonstration program developed in Elmira, New York, studied again in multi-sites. We know that as the old Nurse Family Partnership program. The Parents as Teachers program which promotes a development of children from birth to age three began in Missouri and operated at more than 2,000 sites across the country at the time of this study. The Home Instruction Program for Preschool Youngsters or HIPPY, my favorite name by the way, which seeks to prepare three to five year olds for kindergarten and first grade. And finally, the comprehensive child development program which was a five year federal demonstration program that worked with poor families in twenty-four sites to promote children's development, parents' ability to parent and family self-sufficiency.

And this is what they found. They found that the results varied widely across program models, across program sites implementing the same models and even across families at a single program site. So on the surface, that's a little disheartening. But, you know, a lot of good lessons are learned out of any evaluation and any try of what we do. They said that went on further to report that several home visiting models produced some benefits in parenting or the

prevention of child abuse and neglect on at least some measures.

So that they were not hopeless, just perhaps not as effective as they'd hoped. That no model produced large or consistent benefits in child development or in the rates of health related behaviors, such as acquiring immunizations or well baby checkups. So that is what they did not do well. Two of the programs explicitly sought to alter maternal life course. And when they talk about that, it's in terms of education and employment gains over time. And, of course, of those, one produced significant effects at more than one site when assessed with rigorous studies. We know that to be, of course, the Olds model.

In most cases, research has not identified the key elements that would predict which families would benefit from a home visiting model or which program sites will succeed. And unfortunately, although there's another study going on right now that's still true, there's not good firm data out there. We don't have some of the same body of work that we have in the primary prevention world where we know key characteristics of programs and we've come to understand all about the risk behaviors we have to change and what

determinants will change those risk behaviors. We're not there yet with pregnant and parenting teens.

They also went onto say that most programs struggled to implement the services as intended by their models and to engage families. And that that the families received only about half of the number of visits intended. And that between 20 and 67 percent of the enrolled families left the program before services were scheduled to end.

And this is really important. Because I know that in the work that you're going to be doing, as in all of the work that's coming out of the Office of Adolescent Health, you know, implementation with fidelity and sustainability are critically important.

And a big lesson, I think, from looking at grants such as these is you can't say the program didn't work if the program really wasn't delivered in the way that it was supposed to be delivered. So those aspects are incredibly important.

They said that staff skills, training and turnover and the extent to which the curricula are delivered to families as

intended certainly may affect program outcomes, which we all know to be true.

Now, fast forward to 2010 to look at some recent activity around home visiting, we know that there is a nice home visiting program that's come out of this administration as well, that the Administration for Children and Family recently funded seventeen cooperative agreements under the Patient Protection and Affordable Act of 2010. These are the programs that they have funded, Healthy Families America, Nurse Family Partnership, Parents as Teachers, Positive Parenting Program and Safe Care. And some of these you can see were assessed in that previous report, some were not.

But what they have done is they're working with Mathematica to make sure that in fact implementation with fidelity and replication to scale is done effectively. And this Mathematica has created this guidance for effective replication to scale, including data collection and adaptation. That's one of the resources that I brought just a few of that you can peruse. It's available at supportingebhv.org (evidence based home visiting.org).

And as an aside, I found it to be a really helpful document in thinking through how to effectively…and using evidence based…bring approved effective project to scale. So it's not that long. It's not that dense. But it's really well done. I highly recommend a read.

Moving along to 2004 and Lorraine Klerman's report, "Another Chance". Now, Lorraine was looking just at how you reduce subsequent births, which is part of what we want to do, but perhaps not everything we want to do. But her report and her assessment of the literature was restricted to only that outcome. She studied fourteen programs in the end based on the following criteria to be included. They had to target pregnant and parenting teen mothers exclusively or primarily or at least conduct separate analysis for teens. Had to operate within the United States in 1980 or later, used experimental or quasi-experimental design for the evaluation. Had a sample size of at least fifty in both the intervention and comparison groups and the teenage mothers were followed for at least twelve months after the initial birth.

She found pretty mixed results for the most part. Some of the programs that had showed some mixed results were

Project Redirection, which was a community based program, Parents Too Soon, a multi-site program, and the teenage parent welfare demonstration program, also multi-site. And in terms of what they found in terms of variance, some found some change at twelve months, but not at twenty-four months. Some found mixed change depending on the sites. Some sites had some significant decreases in birth, some sites didn't. And you have the full report. So you can take time to read those and make yourself more familiar with what the programs were about.

The programs that showed significant results at either twelve or twenty-four months of reducing teen pregnancies included a hospital based program called comprehensive adolescent program. Another hospital based program called the Teen Baby Clinic. So these, of course, are programs for women during prenatal period and through pregnancy and afterwards. The Polly T. McCabe Center, which is a school based which still exists and has gone onto continue to have good outcomes. The Second Chance Club which was a school based North Carolina project ... or South Carolina. I think North Carolina. You have the report. I'm not sure Second Chance Club still exists. And then, of course, the old Nurse Family Program.

And when you read Lorraine's report, it's sort of easy to walk away thinking that of all of these, the Olds program is the only one that really, really has solid evidence behind it. That's not exactly true. But it is in a sense true because it's the one that's had the most studies attributed to it. So they are able to backup their outcomes over and over again. But some of these other programs fared well as well.

Now, some caveats about this relying on what this report has to say. So a lot of these programs were operating in 1980. And we have different methods of birth control now, many of which are much more effective. You have to take that into account. Many of these programs did not articulate reducing secondary birth alone as their goal. They articulated other goals such as school completion or graduation. And some of these programs met those goals while not meeting the preventing subsequent birth goal.

Some of them measured their repeat pregnancy and birth at thirty-six and forty-eight months. That's a long time to kind of expect a program to have an impact on a young person's life. And you may not ... you might be stretching

it to find any program that's going to hold that kind of impact four years later. Even for adults for that matter.

These were very small sample sizes, fifty in each group. So you need a large change in order to see a statistically significant difference also can impact what we have to say about that. And many of these programs were based on participation in what was then AFDC. And that no longer exists. So a lot of these programs you can't really translate into current time. Many of them relied on the teen mothers coming into welfare offices for receipt of services in order to engage them in the program as an example.

Okay. The next resource. What makes a difference? Hopeful Practices for Teen Parents. We did a literature review in December of 2007. And what we wanted to do is we wanted to see if since Lorraine had published her report in 2004, anything new had been published in the peer reviewed journals on reducing subsequent birth to teens. We also wanted to go back and look at not only what Lorraine had gathered, but any other information for additional outcomes.

Keeping in mind that Healthy Teen Network, while we certainly support reduction of subsequent births wholly and completely, we also use more of the CAPT framework. So we like to look at other outcomes as well. We used essentially the same criteria that Lorraine used. And we didn't find any subsequent peer reviewed reports on reducing subsequent births at that time. So we didn't find anything new that had been published in a peer review journal through pubmed, et cetera, et cetera, that was in addition to what she published in 2004. We did, however, in looking at some of the programs that she had included, as well as additional programs, find some that had outcomes other than preventing the subsequent birth among teens that are probably worth looking at.

What I've also done today is look at Klerman's results, to look at what I've found in our literature review and to look at the Future of Children. So the first three reports that I've presented to you, here's where they overlap in terms of which programs they recited across one or more of these reports. The comprehensive adolescent program at Queens Hospital, this prenatal, post-partum care, using a comprehensive teen approach with social workers, clinicians and health educators. There were classes in contraception

and family life. Participants were supported through age twenty. They used a quasi-experimental design. They showed a decrease in teen births. This showed up in Klerman's report. We also found increased education and employment as positive outcomes when we did our literature review.

The Teen Baby Clinic. This was another hospital based program that used enhanced postpartum care and a team approach with social workers and an emphasis on family planning. This was a randomized clinical trial. And it showed decreased birth at eighteen months in Lorraine's report.

In medical and community settings, Project Redirection was funded by the Department of Labor and the Ford Foundation and engaged welfare recipients under eighteen years, involved them in service coordination, employment training, used individual education plans and role models. Using a quasi-experimental design, they found a decrease in births at twelve months only, but not further out. But we also in our literary review found that there were changes at sixty months which includes increased employment among the targeted groups. So this is more of the life course change

over the long run that's sometimes referred to in the literature.

The Teen Tot Program. Primary services offered to infants of teen mothers for the first eighteen months. Again, a hospital based program. They offered parenting and decision making support for moms. And the kids who were engaged were eighteen ... sixteen and younger. Using a quasi-experimental design, they could demonstrate better school attendance at six months according to our review, but no changes in the subsequent birth rate according to Lorraine.

Among the school based programs, the Polly T. McCabe Center, which is in Connecticut. Oh, look at there, Second Chance is in South Carolina. Wrong guess on my part. This is an alternative public school. They offered additional pregnancy related, education, social and medical services. Using a quasi-experimental design comparing within groups of those spending more or less than six weeks in the program post-partum, they saw significantly lower percentage of births at twenty-four and sixty months, according to Lorraine's finding, strong findings.

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The Second Chance club was within an urban high school. They met weekly to focus on parenting, career planning, school participation and included case management and home visits with a quasi-experimental design. They found a significant difference in repeat births at thirty-six months as reported by Klerman.

Among the home visiting programs, Parents Too Soon. This is a multi-site home visiting based model, using a quasi-experimental design. Showed mixed results in delaying subsequent births according to Lorraine, improved education and employment outcomes, according to our literature review.

Healthy Family America. Primary focus is reducing child abuse. Had a multi-site evaluation. Showed good results across several domains, including the mother's education and employment gains. And that was in the "Future of Children" report.

And then Nurse Family Partnership. The gold standard has shown many repeat successes using randomized clinical trials, has showed delayed in subsequent births and

increased education, employment, as reported by both Lorraine and the "Future of Children" report.

Again, home visiting models. The Family Growth Center employed an ecological model to teen parenting with very comprehensive services, case management and home visiting. In the quasi-experimental design, they showed improved education among the mothers at three years in our literature review. Field, et cetera, in 1982 compared three models, home visiting, parent training and nursery parent training, with the nursery model faring better than the rest for education outcomes. We found this in our literature review.

Okay. Science and Success are... the fourth now, I think, resource. Advocates for Youth put our Science and Success in 2009 and they looked at programs that worked to prevent subsequent pregnancies among adolescent mothers. So it's sort of update to the Klerman report. However, it was slightly different criteria, therefore getting slightly different results. And it's important to understand the difference in the criteria so you don't look at these two things and try and reconcile.

They in fact also wanted... the articles had to be published in a peer review journal. They had to also use an experimental or quasi-experimental design. But they wanted a minimum of 100 in their case and control group. So they doubled the sample size. So that would shoot out some of those that Lorraine had reviewed. The study needed to collect baseline intervention data on both groups. They needed to collect their data at eighteen months post-intervention or later. So they didn't stop at twelve months…had to be eighteen months or later.

And they had to show program effectiveness in reducing teen pregnancies among the cases or intervention group. So those were there criteria. They also reported that all of the programs promoted contraceptive use. They all promoted education completion. And they all promoted future visioning.

And I know that I'm sort of speaking to the choir when I say this. But, you know, these are some of the really critical things I think you include, access to the information and contraception. We know for everybody if you're not going to get pregnant, you have to know how not to. And then you have to have access to the resources to

prevent it. I mean, that's really basic. But I think when you are talking about pregnant parenting teens in this repeat of the future pregnancy, you really have to think about their motivation to not have another baby. And that's so much about the envisioning and finishing school and seeing a future other than just lots of kids at a young age. Hard work, but necessary component.

All these programs did reduce pregnancy and birth among their cases. And some also improved education and employment outcomes, maternal morbidity or health outcomes for the babies, including reduced infant abuse and neglect. I hope you can see this. What I did here is I took the programs that Advocates for Youth reported. That's the column on the left, Queens Hospital, as being effective. These are the ones they reported as begin effective. Health care for first time moms. Nurse family partnership, Polly McCabe. Women's Jamaica Program, home based mentoring and intensive school based. And you can see they all reduced the repeat pregnancy or birth. Women's Jamaica and the Queens Hospital increased contraceptive use, et cetera. You can read across the column.

The bolded programs, the Queens Hospital, nurse family partnership and Polly T. McCabe, those were also reported in Klerman's report. So there you can see where the overlap was for those two reports. So Queens Hospital obviously had nice impact across every outcome that was measured. Again, a hospital based program. I described it briefly earlier. You can find it somewhat described in both of those resources.

Nurse Family Partnership improved baby health and outcomes, reduced abuse and improved employment as well. Women's Jamaica Program also I believe a hospital based program had outcomes across... good results across multiple outcomes.

In addition, these are programs that when we did our literature review didn't have reducing subsequent births as an outcome, but did have some impact on education and employment. So I just call them to your attention. All of you also... is reducing or delaying subsequent births an outcome for every program in here? No. Most programs? How many programs? Most programs. And is school completion? No. Child outcomes?

MS: We're domestic violence [inaud.] Stay Safe.

DR. PATRICIA PALUZZI: Okay. So domestic violence. Okay, great. All right. So this is still useful then if not all of you are looking at reducing subsequent births. The educational services for school age parents program, RESP, established family learning centers. These are all programs that had some positive outcome and education. Schools, combatting abuse and neglect, combined education and counseling.

In Warwick in 1993, they compared several models of school based education focused programs for pregnant parenting teens. These were programs located within the school grounds fared better than those that were not located within the school grounds. Plainfield Teen Parenting Program offered a comprehensive set of services, education and support.

In addition, these other school based programs Barnett reported a comparison of school based health centers to non-school based health centers, with school based health centers having more success in keeping parenting teens in schools. And all these programs to note had a comprehensive set of support and educational services, all had a positive impact on school retention and graduation.

There are, however, some issues with the scientific rigor of some of these studies. And I would highly recommend that before you would try to adopt that you made yourself readily familiar, more thoroughly familiar with how well evaluated some of these were.

Okay. With all of that, and that's a lot, what seems to matter? If you read the reports about what people say based on their results and what they think, we know that adequately trained and stable staff matter a lot. That if you've got a revolving door that you know your clients never really connect. Because staff relationships with participants matter a lot. Particularly when you're employing a case management kind of system, that relationship is critically important.

Fidelity to the program. I mentioned that at one point. I can't say it enough. Because without fidelity to the program, even the best program is not necessarily going to get you the outcomes you're expecting. All these programs, those that have been assessed have been assessed based on a dosage of a particular set of events. And if you change some of those like what we call core components, you've changed the program essentially.

Research looks like home visiting programs may encourage better relationships, looks like school based settings might improve school retention. That there maybe positive results... we know, we've seen it... for improving school retention, education and employment that might be independent of effects on reducing or delaying the subsequent births.

The comprehensive services with easy access and a lot of support are key. All of the programs that were successful had like case management models and very intensive kind of counseling models. Again, it's not easy work. Complicated population takes a lot of support.

We've got to talk about the teenage dads for a moment at least. Because we do tend to focus on the women and the children only because the women are the more captive audience…obviously, easier to identify them, et cetera, et cetera. But we really do have to pay attention to the dads. I think for lots of reasons. One is we want them to father their children. And we want that to happen even if the relationship is not one of intimacy any longer. And so we need to kind of understand who they are. And we need to

begin to understand how we can better work with them. How many of you are going to be working with teenage dads? Okay, good.

All right. So we know that most teenage fathers are close to their partner's age, regardless of what the news media like to hype, that really it's about 86 percent of both 16 year old and 19 year old teenage fathers have partners or the mothers of their children who are within two years of their age.

…That most teenage males would be upset if they got their partner pregnant. This is way more than 50 percent. Although, we do see some differences within racial and ethnic groups, with Hispanic population reporting being less upset. Most babies born to male teenagers do not live with their families. This is a very high percentage, over 80 some percent, 88 percent I believe. These are data from the National Survey of Family Growth in 2002.

I'm not reporting a long litany of what's been proven effective with fathers. We don't have a long litany that I'm aware of. But I have spent a good amount of time reading some of the literature and I'm going to tell you

what I've gleaned from it. That prenatal engagement, of course, we know that having the fathers engage prenatally and present at the birth seems to help them stay involved longer in the rearing of their children in co-parenting. And that in further looking at this, it looks like there are some data which are showing that engaging the young dads in co-parenting classes prenatally is much more helpful in keeping them engaged down the road with raising their children.

That doing these co-parenting classes seems to help to have an influence on both the mother and the father to understand that relationship that they should try to maintain to parent that child regardless of what happens in their relationship. And so I highly recommend that you look into those findings and you consider co-parenting, prenatal co-parenting classes, if you're able to do that.

You know, the males tell us... we've had a lot of males come to our conference and talk about things. And they talk about they need to feel welcome in the program. You know, is the clinic one that looks like it's so dominated by females that they really have to kind of, you know, get it mustered all up to come in the door. And I think that's

more than just putting a man's magazine on the table. So maybe kind of thinking that through with maybe some focus groups with young men.

Creative approaches to child support. Now, I don't know how many of you are going to work in the policy arena, but this is a really interesting one because really a lot of the disconnective dads goes way, way back and is very policy driven and continues to be somewhat policy driven today. And for those of you who've been in this field for awhile, you're well familiar. But there have been some pretty creative approaches with the funding of TANIF dollars. So that some communities have taken TANIF dollars to do some very creative outreach to teen fathers,such as bypass dollars in terms of child support.

And what that basically means is as I understand it, a lot of moms are not listing who the father is on the birth certificate. Because if they list the father on the birth certificate, then the father's mandated to pay child support. If the father pays child support, that in many states reduces the woman's TANIF income. So she doesn't really gain anything by that.

So she might broker a deal with him sort of outside that she won't name him. He'll pay her child support outside of the system. She gets his child support. She gets her TANIF. Well, then he flakes out on child support at some point potentially. And he doesn't have any records to show that he ever paid any. So he's kind of in trouble. You can see sort of how this goes. It's not really a good win for anybody.

And so there have been some states who have done this pass through where the child support does not reduce the TANIF payment. I think it reduces it some, but not as much as it would otherwise. And so it's a way of encouraging women to establish paternity at birth. So that they have a way to kind of keep these fathers engaged, not just for child support, but in hoping that they're able to maintain relationships. So very interesting information if you're going down that road at all in your programming.

Supporting education and employment for teen fathers would be an important aspect of a program. And, you know, we're really... I really think that we also... we let the men off the hook and then we kind of hold them responsible in that same way around prevention. You know, we really gear our

prevention, our messages, all towards girls, birth control, emergency contraception, what have you. It's the girls. And it comes out of the old silos of maternal child health and whatnot. And we have to go in and get the pap smear. So we're captive by our bodies in a sense.

But we kind of, we haven't really made the males as responsible in this country in the same way as we've made the girls responsible. And then we're mad at them for not being responsible. So we have to kind of reconcile that. We have to kind of come to grips with how we might change engaging them more in the prevention conversation. And I think we could be really creative with that. And have been engaged in a number of focus groups and have read of others where young men really want this information. Because they're not getting it.

I mean, girls might not get it in the way we think they should. But guys really don't get it. They're not going into see an ob/gyn or a nurse practitioner or a nurse midwife annually or every three months for a pill where they might be able to ask them questions. So it's something to keep in mind.

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All right. Where does this lead us? Almost to the end. It's a lot of information, isn't it? This is still a fairly small body of literature. And there's a lot of methodological issues in a lot of the studies that have been. And so, as I said at one point, we're nowhere near the amount of rigor for outcomes that the primary prevention world is,even when we're just looking at preventing subsequent births.

We know that the adolescent family life grant results over the years are in the process of being assessed. And we hope that that information will be coming out in the next year or so. And that might help to inform us more about all of the work that's been done over the decades of that funding and what that might tell us.

We know because we don't have a lot of programs that we can say this one really works. It's got solid evidence. That we have to use that evidence of science based principles when we design our programs. We can at least do that. And that there's a... it's called the CAC analysis. I always have to read the title of this. The Tool to Assess Characteristics of Effective Sex and STD, HIV Education Programs, TAC Analysis.

This is helpful for strengthening programs when you're looking at risky sexual behaviors. So this is something that you can use to refine a program just for those behaviors,because it's really a primary prevention focused tool.

An adaptation, of course, has to be done very carefully. Because if we're not even sure exactly everything that works in the primary program, then we really have to be science based on any adaptations we're going to make.

Here are seven evidence based approaches that you should follow if you're going to be developing or adapting a program. You need to use social science research to assess your needs and the resources of the youth community. So this is your needs assessment…which I'm assuming everybody had to do a needs assessment in order to get this grant in the first place.

So you looked at who your kids are, the population you're trying to serve, what their needs are, what resources already exist,that you use health education and behavior theory to select your relevant behaviors and determinants.

So if you're familiar with the BDI logic model, Behavior Determinant Intervention logic model, good logic model for saying these are the outcomes we want to achieve if I want to achieve those outcomes, these are the behaviors I want to change. These are the behaviors I want to change. These are the activities or interventions that I know impact those behaviors.

That we implement with fidelity. I think I've said that more than anything else now in this talk. That we make informed adaptations. That we use these seventeen characteristics of an effective program. And again, these are only for your teen pregnancy and HIV, not for your other support services. And that we conduct process and outcome evaluations. You can't know how well you are doing in your program if you're not checking that along the way. And if you're not clearly working towards measuring the outcomes you delineated to begin with.

Healthy Teen Network has developed a young family BDI logic model. And it's about, I don't know, 25 pages long. It's ridiculous really. But, you know, we started with the CAPD. You saw all those outcomes that they articulated. Well, if you start looking at all of those outcomes and all

that it takes to impact all of those outcomes and that all you can do to impact all that it takes to get all of those outcomes. I think it started out at like 50 or 60 pages. I said, no. We can't even publish this. This is ridiculous. You know, nobody... I won't read it, let alone expecting anybody in the field to read it. I think we got it down to twenty some.

But basically, I'm going to give you... so we looked at the same outcomes that CAPD looked at. We looked at the self-sufficiency goals for young mothers and fathers, the developmental goals for children of young mothers and fathers and goals for young families. And we articulated basically some of the same goals with slight changes from what CAPD did in 1996. We said we want to increase high school graduation or GED completion. We want to increase completion of post-secondary education, be it vocational training. We want folks to get to employment and a livable wage.

We want to increase self-reliance in transition to safe and stable housing. We want to reduce or delay subsequent pregnancies and births. And we want to reduce sexually transmitted infections and HIV.

In terms of the developmental goals for their children, we want to increase healthy births as well as age appropriate physical, emotional, cognitive and social development and school readiness. And for the families, we continue to say we want to increase appropriate discipline, nurturing behavior and children who are well cared for and healthy relationships between partners, peers and families.

This is one thread of what the model looks like. And you can get this model from our website. And I would say it might be useful to help you in looking at what you've thought of in your own logic models and there might be things in here that you would adapt for your own use. This was done. It took a long time to do it. We used a lot of experts in the field to respond to this. So it's pretty well vetted. So how you would read this, for example, is from right to left.

So if here we're looking at the goal of we want to increase the length of time between the first and second pregnancy, reduce the number of subsequent pregnancies and reduce the incident of STIs and HIV/AIDS. So, you see, that's how we got it down to twenty some pages. We collapsed a few

outcomes, right? So in order to do that, these are some of the behaviors that we have to change. We have to delay initiation of sex. We have to increase correct and consistent use of contraception, increased testing, et cetera, et cetera.

Now, the pink here is the thread that's followed further to the left. So see, they'll be a different logic model for delaying initiating of sex and a different one for increasing testing, et cetera. What starts to the left, these are the determinants that we know impact increasing correct use of contraception, improved belief that peers support the use of contraception is one thing that the literature tells us will help young women and men to be better contraceptors, et cetera.

The green is the thread that follows to the left. So again, the intervention activities that we identify that can help to improve the belief that peers support this, that can improve your constant use and correct use of contraception to get to those outcomes. So this is really all about one behavior and one determinant to impact one behavior.

Okay. So the other thing I did want to mention this, this TAC analysis. Because it is something going you might find useful. This is available through us. I think you do have to pay for it, however. It's a useful tool for assessing evidence based teen pregnancy and HIV prevention programs based on Kerby's work. He delineated seventeen effective characteristics.

If you don't, if you're not sure if you're adapting a program, I think it's really helpful, particularly if you're going to adapt that part of your program to make sure that you're on track with your population's behaviors that you've identified and what you're trying to impact. We don't have that same evidence for the pregnant and parenting teens. But the same principles apply. So wherever we do have evidence, you need to use that evidence.

Effective adaptation. This is really, really the end. It generally depends on preserving the core components. And in the field, we talk about green, yellow and red light adaptations. If you guys are familiar, green light adaptations. If you have the core components of a program, you know the essential things that have to be done in order

for that program to work. This is what Kerby's delineated in all of the primary prevention work.

So green, yellow and red adaptations mean green adaptations are things that you can change and it's not going to change those core components. You should get the same outcomes. So it might be that some of the programs you can't change the dose, but you might be able to change the delivery. You might be able to do two hour sessions instead of one hour sessions.

A yellow light means that you're kind of treading on water where they're not sure if it's going to impact. And so, that's something you need to think about carefully. Red light you can't change. Because if you change that, you're going to change your outcomes because that is considered a core component of the program. You really want to work closely with the program developers and follow evidence based models if you're going to do any adaptation.

And I would assume that you would pilot test. Because really if you don't, you're still not sure if with your population that the adaptations that you made are going to be effective. So it's a really critical piece of

implementing an evidence based program at any point in time. Because otherwise, you don't want to scale up and be spending the big bucks and find out that you should have changed something right in the beginning.

That's the end. Plug for our conference, of course. I always have to do the public announcement. We are looking at bridging the gender divide in Pittsburgh in October. We would love to have you there. Again, about half of our attendees are folks who work with pregnant parenting teens. Because that is our dual focus. And we are going to be doing a lot around teen fatherhood as well as males involved in primary prevention.

I am very open to being contacted at any time if you have questions beyond today or if there's any way that I or anybody at Healthy Teen Network can help you. And I thank you for your time and your attention. And wish you all the good luck in the world over the next five years, five years right? Five years with your programs. Hope to be seeing you again and again. Thank you. [applause]

MS. EVELYN KAPPELER: I just want to clarify for the pregnancy assistance fund, these are three year project grants.

DR. PATRICIA PALUZZI: Oh, sorry, sorry.

MS. EVELYN KAPPELER: We have a whole other set of teen pregnancy prevention grants that are funded for a five year period. We do have some time and Pat is available to take some questions and answers. I would ask that if you have a question, if you would please use the mic. Give us your name and your agency before you pose your question. Thank you.

JAN: Hi, my name is Jan. I'm from Minnesota. We kind of have a little bit of a different spin on our pregnancy assistance fund in that we're focusing on young student parents that are in college and working with higher education.

MS. EVELYN KAPPELER: Excellent.

JAN: I think we're maybe one of two grantees that are doing that if I recall. So in working on our application, there's really a dearth of research on this population. And I was just wondering if you could articulate any thoughts you might have around working with young student parents and higher ed and helping them complete their educational goals and delay a second pregnancy.

MS. EVELYN KAPPELER: You know, it's great that you're doing that work. I would say that I don't think it's going to be a whole lot different to be honest with you. Because, I

mean, first of all, having children who've gone through that period, not parents thank God, but eighteen, nineteen year olds, twenty year olds in college, they're kind of floundering. You know, they still need that same level of parental support that they needed in high school. They might be a little more afraid to ask for it or embarrassed to ask for it. But they need it.

So I would think that just working with these young adults, I mean, really our work is teens and young adults, isn't going to be that much different. Housing is going to potentially be a bigger issue. I know that for a lot of single parents trying to go to school, if there isn't housing that's offered on campus, if they can't, for example, use married student housing, that sort of thing. So housing might prove a challenge that they need some support to advocate to make sure they can get something that works for them.

Of course, child care. I mean, it's going to be the same issues in trying to go to school at the college level. And then you have the added cost, of course, of tuition and such. So I would think you would look at it pretty similarly in terms of a very comprehensive, if not case

management, certainly some sort of very comprehensive set of resources that would serve as sort of a guidance counselor plus, plus, plus.

MS. JULIE COFFEY: Hi, I'm Julie Coffey from Memphis, Tennessee, the State of Tennessee. I noticed that in looking at your evidence based programs, you didn't list Centering Pregnancy which is a model like prenatal care group based prenatal program that Memphis had hoped to pair with our programming. And I just wanted to get your feedback on that.

MS. EVELYN KAPPELER: You know, I've heard of Centering Pregnancy. And as a midwife, it started to become popular before I actually stopped doing clinical service. So I've not had any personal experience with it. And I know that people are happy with the outcomes. But it hasn't shown up in any of the literature that we reviewed. And it may just be that they haven't reported separately on teen moms. And that maybe that they don't have enough teen moms to report anything on. So it might not be a reflection on its effectiveness. It could just simply be a reflection on what's available, what data are available, to give an adequate report. But I have heard wonderful things. And I have heard wonderful things anecdotally for work with teen parents.

So, you know, you can always go and look at sort of what's the theoretical basis? And how well does it fit into some of the evidence based principles we talked about? And if there's some shoring up that you feel you need to do. But it would be interesting if you're able to report on it at the end of your project and add to our knowledge. It'd be great. [off mic audience comment] All right. Which is a huge important one. Because we know that people really struggle, for example, with nurse family partnership in terms of being an expensive model. Great.

MS. NANCY GREENMAN: Nancy Greenman from Oregon. And I think I know the answer to this. In any of the studies, has it been possible to correlate the existence of interpersonal violence to successful outcomes and participants? Or has that not been a consideration? I'm guessing not. I'm guessing that was too hard.

MS. EVELYN KAPPELER: Well, I will tell you that I'm somewhat familiar, although, my familiarity ended a few years back. I used to work in the domestic violence arena. And so I knew the research better back in those days. When you're looking at teen pregnancy prevention, you might find some looking at the relationship piece. But I think you search better and find better when you're actually looking at the

violence literature which is not what I searched for this talk.

But I know that there have been... there certainly are some very definite correlations obviously with intimate partner abuse and teen pregnancy. We did a report, actually two reports, that might be of interest to you. These were literature reviews that were done. One was looking at a history of abuse, particularly intimate partner violence and teen pregnancy that Healthy Teen Network did when we were still NOAP.

So it's probably six or eight years old. And we looked at the literature rather extensively there. And then a few years back, we did one looking at males. We looked at a history of family or sexual abuse on males, early childhood or sexual abuse. And then there are pregnancy and parenting behaviors and adolescent reproductive pregnancy and parenting behaviors as adolescent men. Very interesting outcomes for that, that really speak to... I think it was Alexia mentioned gender norms earlier... really speaks to having to come to some grips about how we view young men in this country and what messages we give them about what it means to be a man, et cetera.

So there are those reports where you could go and look. A little dated... the female one is a little dated. But certainly there are relationships.

MS. JULIE COFFEY: Hi, Julie Coffey again. One more question. Because in Memphis, Tennessee, you fall through the cracks. We have a problem with gap in retention and follow-up because of that. And in reviewing the evidence based programs that you listed and in looking at my own inventory of programs out there. There is not a lot out there that spans several years, zero to three, zero to two, for the most part. But are there any that you listed zero to five, zero to eight?

MS. EVELYN KAPPELER: You know, I couldn't say off the top of my head to be honest with you. I'd have to go back and look.

MS. JULIE COFFEY: There's a lack of those types of programs. I'm sure there are several reasons why. But that seems to be a need in Memphis, holding onto the families.

MS. EVELYN KAPPELER: Yeah, the zero... I mean, I think when you're starting with childhood, they often go zero to three. And then it's a different funding stream. So much of it is about the funding stream. There's the earlychildhood and then et cetera, et cetera. So I'm not familiar. One more question, last question.

MS. JAN CREEK: Hi, I'm Jan Creek from the other Washington.

MS. EVELYN KAPPELER: Hi, Jan.

MS. JAN CREEK: I have a question really similar to Julie from Tennessee in terms of a model in our state, the grads program. And I'm really new to the grant and really new to all of this. I'm understanding it's an evidence based model. But just wondered if you could comment on any literature had you seen about that.

MS. EVELYN KAPPELER: I'm sorry, I can't. Can anybody else? I'm not familiar with the grads program. Does grads stand for... I'm sure it's an acronym. Graduation Reality and Dual Skills?

MS. SALLY KOSNICK: I'm Sally Kosnick. And I'm the Executive Director for New Mexico and we do have New Mexico GRADS. It started in Ohio. And in Ohio, they had a separate vocational ed department and a separate education department. So that's where we got the model twenty-one, twenty-two years ago.

And GRADS stands for Graduation Reality and Dual Role Skills. So they're students, whatever, and a parent. And so we're really excited that there's other states that are interested. Because we've searched for other programs. It's an in school…it's a drop out recovery program in

school for credit. And then we usually have in New Mexico, what we changed was the biggest need was child care. And so we have licensed child care centers in close proximity if not on campus for those students and for staff if there's room, whatever. And those become self-sustaining because of the child care reimbursements. You know, if we can keep them full and stuff.

MS. EVELYN KAPPELER: And what kind of evidence is there for the program?

MS. SALLY KOSNICK: We do our end of year reports. We are under legislative support in the State of New Mexico which is very iffy these days as in many states. But we are under family support services under our public ed department. And so we have amazing results when you really look at our data and stuff. And I did bring a few brochures and stuff in case anybody's interested.

And we have a website. But we're down to three staff in our staff office out of eight because of budget cuts in the last couple of years. So we're trying to pitch hit. So our website's really poor right now to be quite honest. But we're working on it.

But our school retention, you know, to get them through within five years instead of four because we do the case management piece is what we call it even though there are classroom teachers that are meeting them at the hospital and helping them with the day-to-day things and that kind of thing too as part of their support system. But I'd be glad to expand more or give more information to anybody that's interested. It is a great model. But as far as being able to have somebody that is doing an article for a professional journal. So that we can meet this criteria, we're not big enough. We don't have... we're in the trenches working with the kids that we're working with and with their families. And so we don't show up in some of the things. But it really is working. Our graduation rate is 89 percent of qualifying seniors graduating when in the nation, it's 20 percent or something. Our repeat pregnancy is 2.4 when they're in the GRADS program as opposed... and we're not handing out contraceptives unfortunately. But as opposed to 19.4 percent, you know. So we are making a difference, but we're small. We're a small state. We barely hit two million in our entire state population now with this last census. So we're still trying to figure out how to let others know what we're doing and to keep our original funding so that we can keep this grant right now.

That's the worry. Our legislature started yesterday and, you know, so it's always an issue. But I did bring some facts if anybody's interested.

MS. EVELYN KAPPELER: Great. And I think that's a good note to kind of end on by saying you know that you have achieved some good results, but nobody's been able to publish. And I think that in this world for pregnant and parenting teens, because it hasn't been as well funded as the prevention world. Because we started out in the very beginning saying two sides of the mouth. People don't get it. We're just not there. And so using those evidence based principles and making sure that you're just going about this in the most evidence supported way that you can is what's going to be critically important. Thank you all. [applause]

(END OF TRANSCRIPT)