Schuyler Center for Analysis and Advocacy

Teenage Births: Outcomes for Young Parents and their Children

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Schuyler Center for Analysis and Advocacy
150 State Street, 4th Floor
Albany, NY 12207
Tele. 518-463-1896
Fax 518-463-3364
www.scaany.org

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Outcomes for Young Parents and their Children

Preface

The Schuyler Center for Analysis and Advocacy (SCAA) released *Growing Up in New York: Charting the Next Generation of Workers, Citizens and Leaders* in 2006. That report, and two subsequent updates, provide data on what is happening to New York's children in key areas of interest to policymakers.

But children's lives cut across these key areas, and across state systems. Their health, their educational achievement, their economic security all come together to chart their course in life. SCAA staff has taken the idea of using information to tell a story about children to a new level. This report brings together data to show how teen parents and their children fare across these key areas. It is informative to see how investments in programs for youth who have become disengaged from school, greater enrollment of youth in health insurance and the expansion of home visiting can improve outcomes for parents and children.

The impact and consequences of policy decisions are not always recognized or become obscured because of the influence of other factors. Our hope is that this report will encourage policymakers to see relationships between life areas and across systems and take these into account when making decisions regarding programs and budget priorities.

Executive Summary

Teen childbearing is a much-studied, confounding public policy topic that is closely associated with a multitude of social issues, including persistent poverty, school failure, child abuse and neglect, health and mental health issues. Teen pregnancy rates are at the lowest level in 20 years and teen birth rates are at the lowest level ever recorded in the United States.[1] However, teen pregnancy and childbearing are still compelling issues and it benefits the family, and society, if:

- The baby is born healthy and the mother is healthy.
- The child is prepared for school.
- The mother is educated and able to care for the child.
- The mother becomes economically independent.

Prevention and early intervention programs hold the greatest promise for improving the lives of young women and men, and boost the future prospects of their children. Progress can be made on what was once viewed as an unmanageable social and economic problem. Therefore, it only makes sense for New York State to invest in a pre-natal home visiting system that connects to teens when they become pregnant, and provides a continuum of services to the mother, father and child for a sustained period of time.

This paper aims to link data on indicators across various human service domains to help lawmakers develop state policies that effectively reduce teen pregnancy, as well as comprehensive programs for very young parents and their babies.

Children of teen mothers bear the greatest burden of teen pregnancy and childbearing, and are at significantly increased risk for a number of economic, social and health problems:

- The children of teen mothers are more likely to be born prematurely and at low birthweight, raising the probability of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, cerebral palsy, dyslexia, and hyperactivity.
- Children of teen mothers are 50% more likely to repeat a grade, less likely to complete high school and have lower performance on standardized tests than those born to older parents.
- The children of teen parents are more likely to live in poverty and suffer higher rates of abuse and neglect than would occur if their mothers delayed childbearing.
- The sons of teen mothers are 13% more likely to end up in prison.
- The daughters of teen parents are 22% more likely to become teen mothers themselves.[2]

For young women, coping with a disadvantaged background is hard enough. Having a baby during adolescence only makes matters worse.

- Compared to women of similar socio-economic status who postpone childbearing, teen mothers are more likely to end up on public assistance.
- Teen mothers are less likely to complete the education necessary to qualify for a well-paying job—only 41% of mothers who have a child before age 18 ever complete high school. In the past 25 years, the median income for college graduates increased 13%, while the median income for high school dropouts decreased 30%.
- Teen mothers are likely to have a second birth which can further inhibit their ability to finish school or keep a job. About one-fourth of teenage mothers have a second child within 24 months of the first birth.[3]
- Nationally, teen childbearing costs taxpayers at least $7 billion each year in direct costs associated with health care, foster care, criminal justice, public assistance and lost tax revenue.[4]

Teen fathers may experience many of the same adverse outcomes as teen mothers. This paper focuses on mothers, but if the state wants positive outcomes for the children of teen parents, it must also focus on teen fathers. There must be outreach that engages teen fathers, makes them a part of the birth experience, facilitates their continued education, assists them with employment and child support, and counsels them on relationships and parenting.

Teen childbearing also carries tremendous monetary costs for the state. According to an analysis from the National Campaign to Prevent Teen Pregnancy, teen childbearing in New York costs taxpayers at least $421 million in state, federal and local dollars.[5] Most of the costs are associated with negative consequences for the *children* of teen mothers. For example, the average annual cost associated with a child born to a mother age 17 and younger in New York is $6,094. In 2004, annual taxpayer costs associated with children born to teen mothers in New York included:

- $186 million for public health care (Medicaid and SCHIP).
- $204 million for child welfare.
- $203 million for incarceration.
- $117 million in lost tax revenue, due to decreased earnings and spending.

Available data reveal a complex interaction among such factors as poverty, education, disaffection, health and mental health that can lead to children having children. While teen birth rates declined over the last decade, that decrease may be impossible to sustain absent a more encompassing, multi-agency approach that takes into account the intensely challenging lives of many teens.

As part of an overarching public policy approach, SCAA recommends that a formal, cross-systems workgroup, including representatives from the Governor's staff, legislators, agency staff and advocates be established to set measurable, time-specific goals to:

- Develop data sources across agencies that provide a clear understanding of teen child bearing.
- Increase efforts to reduce family poverty by setting a poverty reduction target.
- Expand funding for programs that evidence shows reduce teen pregnancy.
- Keep teens connected to schools for their benefit and the benefit of their children.
- Make adequate health and mental health services available to all teens and their children.
- Provide additional assistance to teens in foster care and those transitioning from foster care.
- Expand programs that strengthen families through parenting skills training, support and guidance.
- Increase the public assistance grant.
- Sustain and grow home visiting programs.
- Provide affordable, high-quality child care for teen mothers.

Prevention is the Best Approach

Research shows that adverse early childhood experiences can negatively impact outcomes in later life. Abuse and neglect, trauma, and parental substance abuse all negatively shape the adult psyche, behavior and health. On the other hand, positive early childhood experiences, such as high-quality early learning and consistent, nurturing relationships with responsible adults, can help lay a solid foundation for success.

While 85% of a person's brain architecture is set by age five, making prevention imperative, it is during the time between childhood and adulthood that the brain undergoes some of its most extensive and important changes. The long-held belief that the brain is fully formed by adolescence is simply not true. In fact, the brain may be at its most flexible, and perhaps precarious, during adolescence. Just as the body is maturing in these formative years, the "wiring" in the brain also becomes more complex and structured. According to research, processes such as reasoning, priority-setting, organizing plans and ideas, forming strategies and impulse control are being developed as the parts of the brain that control these activities are being formed.[6] Adolescence is a time when the brain is still strengthening its executive functions: self-regulation, complex attention, working memory, and decision-making, as well as the ability to initiate and stop activities and appreciate the consequences of behavior.[7]

Because vital parts of their brains have not fully developed, youth are not always able to assess the future consequences of their actions. It is during this time that teens need guidance: the risk of teen pregnancy increases when the age of first sex is under 15, when teens do not use contraceptives during their first sexual experience, if the partner of the girl is older, and if there are multiple partners.[8]

By the time they reach adolescence, young people who engage in negative behaviors are at risk of becoming "disconnected;" young adults who are not in school, not working and with few positive connections to society. Young people who are at-risk of becoming disconnected are the same youth who drop out of school; are involved in the juvenile justice, child welfare, substance use or mental health systems; are runaways or homeless; or become teen parents. Early identification of youth who might become disconnected can steer them into supports and opportunities that encourage success. Youth development strategies such as family engagement and mentoring can be particularly helpful in preventing disconnection.

During this critical time, all youth –especially those at highest risk–need services and supports to help them develop their potential as well as address problems that arise in their lives. Investments in adolescents must build on their strengths and provide encouragement and guidance so they can move to a productive adulthood. Adolescents who were enrolled as children in preschool or a child care program that focused on improving education among disadvantaged children have fewer pregnancies and births than those not enrolled in such programs.[9] Engagement in schools, religious activities and sports (among girls) are associated with positive reproductive health behaviors. Teens who are already involved in other risky behaviors (alcohol and drug use) are more likely to engage in risky sexual behavior.[10]

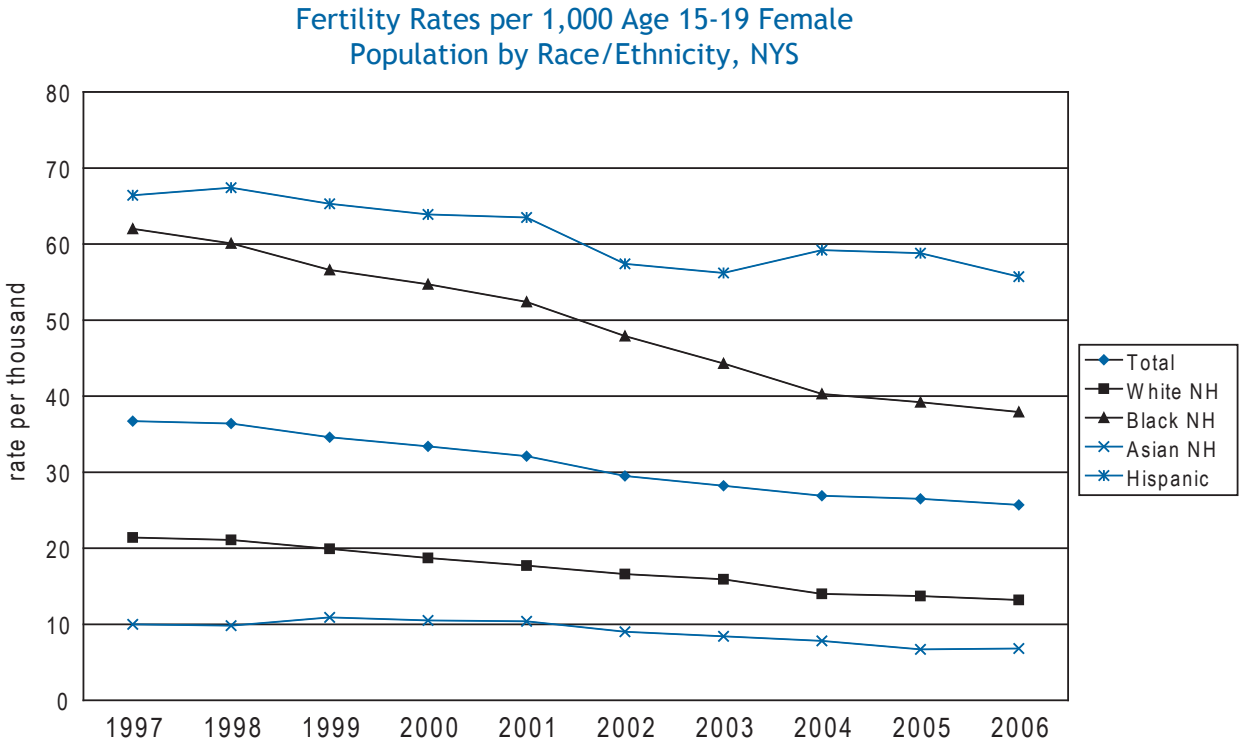
Prevention also extends to programs that are proven to reduce harm and improve outcomes for parents and children. Home visiting and parent education are critically important during the prenatal and postpartum periods because they help strengthen families through support and education. For example, programs that include life skills training can result in a reduction in the frequency and severity of abuse and neglect.[11] The decrease in maltreatment is a direct result of improved parental skills—parents learn in home visiting programs how to manage their anger, how to discipline their children effectively and without violence, and how to ask for help and support when they need it. (*A description of pregnancy prevention programs in New York State is contained in Appendix A.*)

Recognizing the Problem

Teen Births[1]

Fortunately, the number of teen mothers is declining across the United States. The decline is evident across all states, ethnicities and racial groups although teens in minority groups and those living in low-income communities remain at higher risk. New York experienced a decline in rates as well and now has the 9th lowest teen birth rate in the country.[12]

Even with the decline, over 17,000 girls gave birth in New York in 2006 with an overall rate of 25.7 per thousand. Hispanic girls were almost 1.5 times as likely as Black non-Hispanic girls and four times as likely as White non-Hispanic girls to have a baby.



This chart shows the decline in the number of teen births in New York between 1997 and 2006 by the race and ethnicity of the mother. Teen fertility rates are based on live births to women aged 15-19 per 1,000 female population aged 15-19. ***Source:*** *NYS Department of Health*

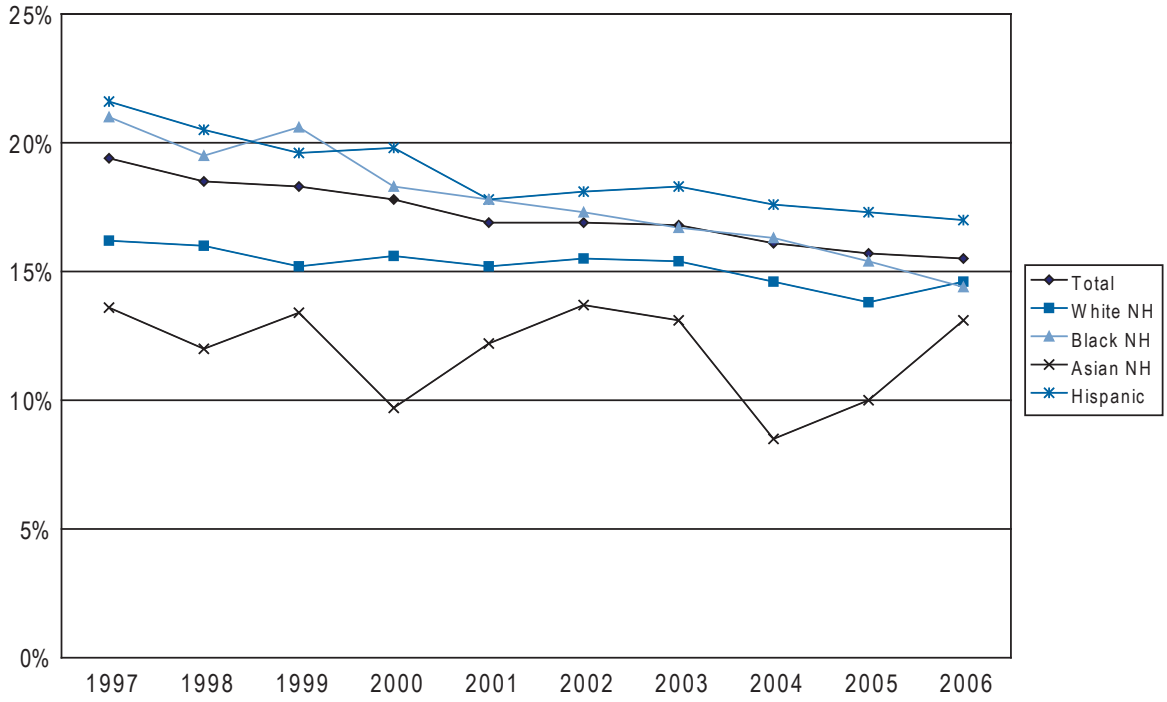
[1] This report looks at births to teens ages 15-19 and does not break the ages down into smaller age cohorts. It is important to recognize that differences in characteristics exist between the youngest and oldest teens and variations will be evident in a more complete breakdown of the data. However, enough similarities exist to generalize the data for the purposes of this report. There are also a small number of births to teens younger than 15 each year in New York State but they are not included in this report because of the relatively small sample size.

Additional Births to Teen Mothers

New York ranks 45th for repeat births to teen mothers.[13] While the number of repeat births has declined over the past decade, it is clear that a second birth compounds the problems resulting from the first birth.[14] Having a second child impedes the mother's ability to finish school or keep a job and to escape poverty.[15]

By race and ethnicity, the percentage of New York teens having a second child range from 17% (Hispanic) to 13% (Asian) while the state average is slightly over 15.5%. This is significant since poorly spaced births lead to poorer outcomes. These children are at higher risk of developmental problems than other children.[16]

Percent Births to Teen Moms with a Previous Birth by Race/Ethnicity



This chart shows by race and ethnicity the number of teens having two of more births between 1997 and 2006. The rate has declined slightly in that time with a reduction in the total number of almost 4%. ***Source:*** *NYS Department of Health*

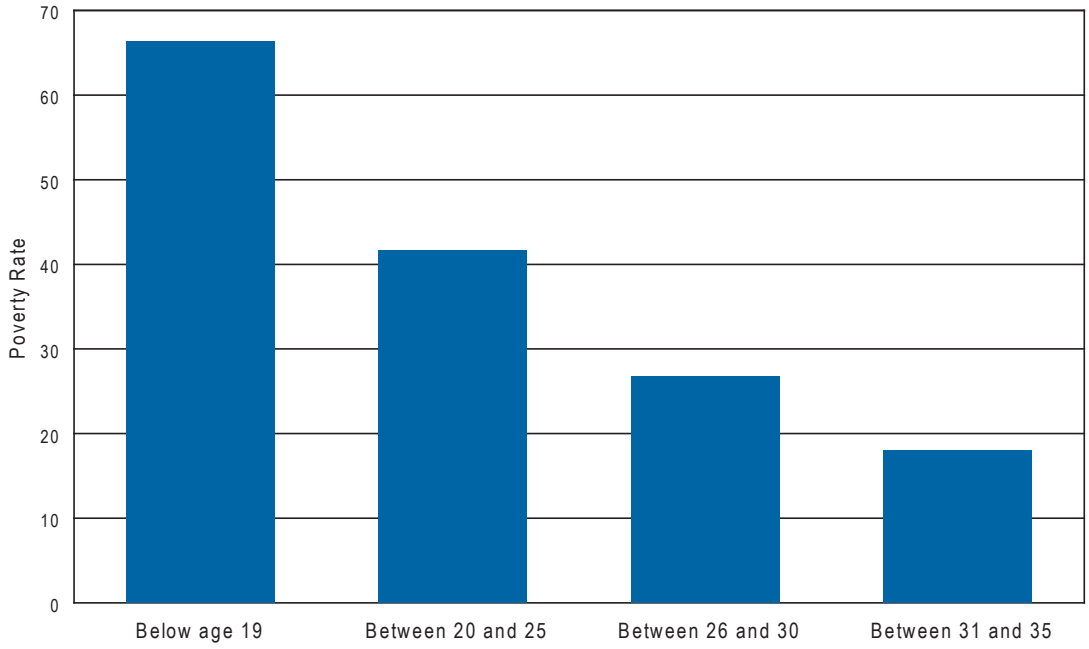
Poverty: Both a Cause and a Result of Teen Childbearing

Research demonstrates that childbearing during the teen years is both a result and cause of poverty.[17] The same complicated set of socio-economic factors that puts teenagers at risk of childbearing also contributes to the reality that teen parents continue to live in poverty. These are teens with less education, members of racial and ethic minority groups, and those who live in communities with high rates of both poverty and non-marital births.[18] While it is true that some children will be raised in poverty regardless of the age of their parents when they were born, teenage childbearing perpetuates the liability of poverty on the mother and the child.

According to research, "A greater proportion of young women who are poor become sexually active as adolescents, do not use a contraceptive method at first intercourse and give birth by age 20."[19] These youth also have "lower self-efficacy in obtaining and using contraceptives effectively."

Compared to mothers just ten years older, teen mothers are almost three times as likely to require some sort of public assistance. Waiting just a few years to have children can reduce the odds of living in poverty by almost 20%.[20] In New York, teen mothers are far more likely to live in poverty than their non-parent peers.[21]

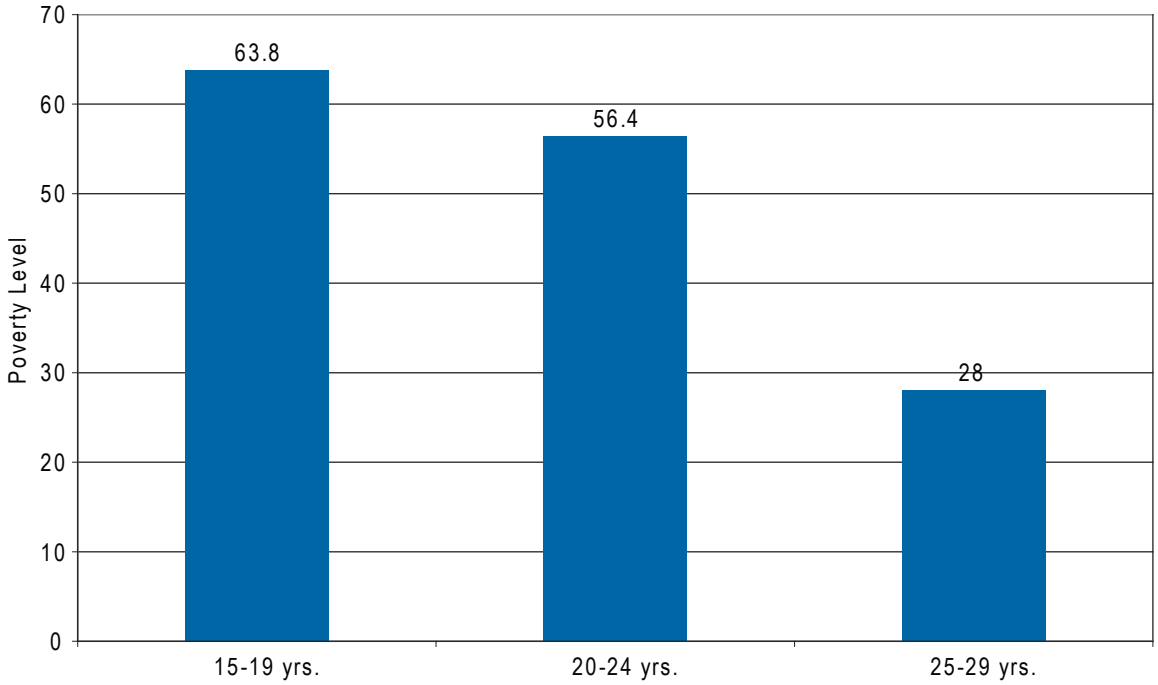
Poverty Rates of Mothers by Age, New York



This chart shows poverty rates for mothers in New York State by age. Mothers below age 19 are 1.6 times as likely to live in poverty as mothers just a few years older.
Source: *US Census Bureau*

- The poverty rate for children born to teenage mothers who never married and who did not graduate from high school is 78%. This compares to 9% of children born to women over age 20 who are currently married and did graduate from high school.[22]
- Two-thirds of families begun by young, unmarried mothers are poor.[23]
- 52% of all mothers on public assistance had their first child as a teenager.[24]
- A cost benefit analysis suggests that the government could spend up to eight times more than is currently being spent on teen pregnancy prevention and still break even.[25]

Participation in Public Assistance* by Age of Mother For Mothers Who Had a Child Within Last Year



*Participation in Public Assistance means participation in one or more of the following programs, Temporary Assistance for Needy Families (TANF), Food stamps, Special Supplemental Nutrition Program for Women Infants and Children (WIC), Medicaid, Housing Assistance, General Assistance or other Welfare.

This chart shows the percentage of mothers who have had a baby within the last year that are living in poverty. Nationally, teen mothers are more than twice as likely as mothers between ages 25 and 29 to live in poverty. ***Source:*** *US Census Bureau*

What Are the Chances?

What are the chances of a child growing up in poverty if (1) the mother gave birth as a teen, (2) the parents were unmarried when the child was born, and (3) the mother did not receive a high school diploma or GED?

- 27% if one of these things happen
- 42% if two of these things happen
- 64% if three of these things happen
- Only 7% if none of these things happen

Put another way, if all three factors exist, a child's chance of growing up in poverty is nine times greater than if none of these happen.

Source: *Why It Matters: Teen Pregnancy, Poverty and Income Disparities*, The National Campaign to Prevent Teen Pregnancy

Educational Achievement and Social Development

The consequences of teen childbearing are reflected in the lower educational achievements of both the mothers and children. Making up for the lost time and reduced opportunities afforded to these groups is costly and time consuming.

Of the 63,000 high school drop-outs in New York in 2006, it is safe to say that some were teen parents—both mothers and fathers. Pregnancy can complicate the school experience. Expectant mothers may need to deal with stigma and unwanted attention. New parents have less time for their studies and for sleep. They must also handle adult responsibilities they are not ready or equipped for, including juggling complex child care schedules and providing child support. Many must work to support themselves and their baby. None of these complications are conducive to completing school, and either continuing their education or starting a career.

Teen Mothers

- Nearly one in three girls cited pregnancy as the reason they dropped out of school in 2004.[26]
- Even after controlling for race, economic status, and other characteristics, having a child before the age of 20 reduces academic attainment by almost three years.[27]
- Only 63% of teenagers who give birth before age 18 either graduate from high school or receive their GED as compared to 85% of women who delay childbirth until their early twenties.[28]
- Only 5% of young teen mothers complete at least two years of college by age 30 and less than 2% obtain a college degree.[29]

While parenting is difficult for teens, their children are starting life at a distinct disadvantage. Their parents probably lack life experience, skills, maturity, and economic security. Chances are the pregnancy derailed the parents' education and life plans. In other cases the parents were already disconnected from their future. Supports such as home visiting and parent education are important in order to break what could become a cycle of adverse outcomes visited on both the teen parents and their child.

Children of Teen Mothers

- Children born to mothers ages 17 and younger begin kindergarten with lower levels of school readiness, including lower math and reading scores, language and communication skills, social skills and physical and emotional well-being, than children of older mothers. Children born to mothers ages 18-19 do not perform much better on most measures.[30]
- Children of teen mothers are 50% more likely than children of older parents to repeat a grade, are less likely to complete high school than the children of older mothers, and have lower performance on standardized tests.[31]
- Children of teen mothers are more likely to be unemployed and to become teenage parents themselves than those born to women who delay childbearing.[32]
- Children born to teen mothers are at greater risk of social behavioral problems and are almost three times as likely to be incarcerated during their adolescence or early 20s as are the children of older mothers.[33]

Health and Mental Health

The Importance of Good Health

It is in New York's interest to promote polices and programs that support the health of the children of teen mothers. The positive and negative consequences of childhood health are far-reaching and lifelong. When children are not treated for medical, dental and emotional problems they can incur greater health care expenses, loss of earning potential later in life and a reduced quality of life. Healthy children learn better in school, miss fewer days of school and are more likely to become productive, healthy adults.

It is also important to support the health of the teen mothers since healthy caregivers are better able to care for their children.

- Research indicates that children of teenage mothers are less likely to receive proper nutrition, health care and cognitive and social stimulations than children of women who delay childbearing.[34]
- Children were more likely to be reported in "fair/poor" health than "excellent" health by their teen mothers.[35]
- The children of teen parents also suffer higher rates of abuse and neglect than would occur if their mothers had delayed childbearing.[36]

Health Insurance

Health insurance – whether privately or publicly sponsored – is positively associated with key indicators of children's use of health services.[40] While many factors, including inconvenient office hours for working families, language and cultural barriers, high co-pays and deductibles and lack of providers can influence when and if families receive care, having an insurance card encourages the use of preventive services and can increase health status over time.

New York State provides health insurance through Medicaid and Child Health Plus to all children under the age of 19. It is now possible for all teen mothers to have health insurance, which means that teens can have coverage for gynecological exams, counseling and contraceptives when they become sexually active.

Infants in New York whose mothers are enrolled in Medicaid at the time of birth are automatically enrolled in Medicaid until their first birthday but they are not automatically enrolled if their mother is uninsured or on Child Health Plus. These children will remain uninsured unless the mother is informed of the need to enroll the child, and initiates and completes enrollment. This lengthy process might deter teen mothers from enrolling the child.

Prenatal Care

Early, comprehensive prenatal care is essential to a healthy birth. Prenatal care can help reduce the incidence of perinatal illness, disability, and death by providing health care advice to mothers and identify-

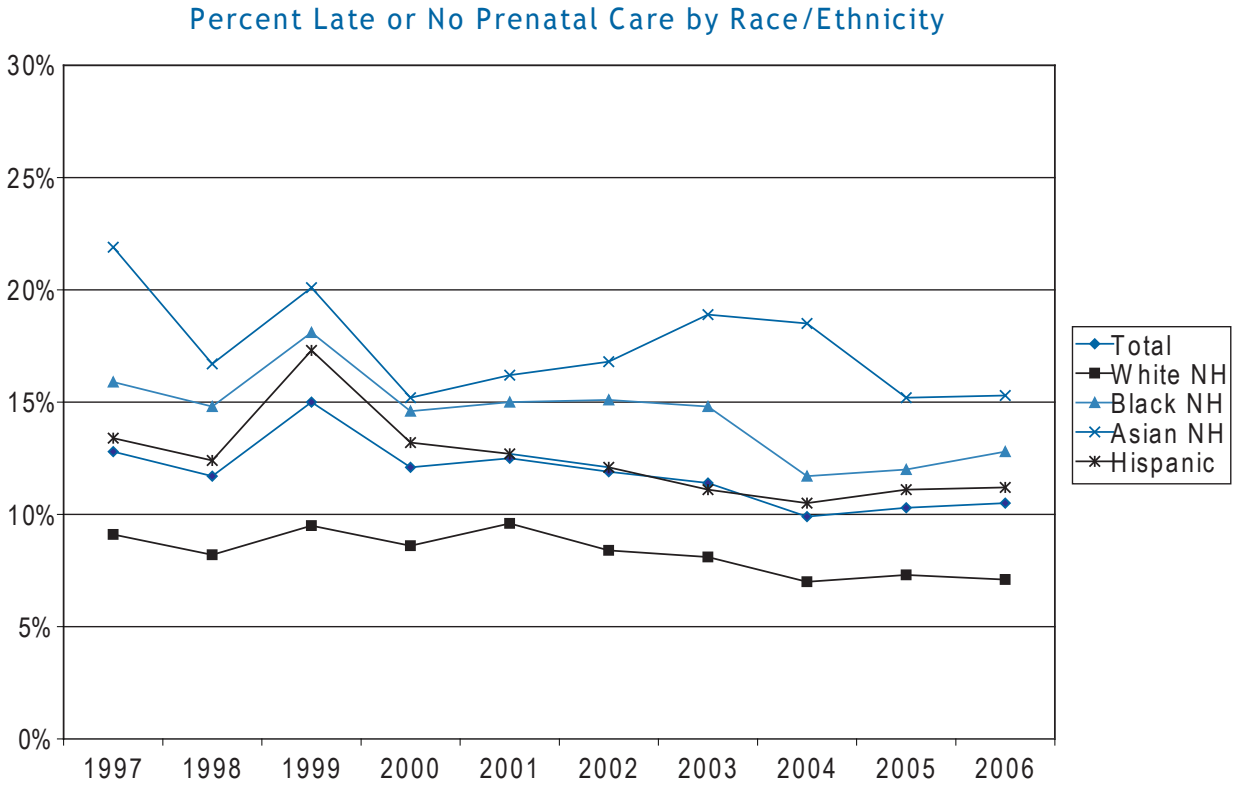
- Among New York State teen mothers, almost half (46.8%) report smoking in the three months before pregnancy. More than one in four (28.1%) report smoking during the last three months of pregnancy and 40% return to smoking after the delivery of their baby.[37]
- Mothers with health problems or depression may not be able to continuously supervise their children to prevent household injuries.[38]
- Maternal literacy has a strong positive effect on child health because parents with higher literacy are more effective users of the health care system.[39]

ing and managing any chronic or pregnancy-related risks.[43] There is an increased risk of low birth weight (LBW) births to women who receive late or no prenatal care.[44] Healthy People 2010 set a goal that 90% of adolescent mothers receive early prenatal care, yet both New York and the nation as a whole fall well below this target.

- Between 1998 and 2006, 73% of births to teen mothers in New York were covered by Medicaid.
- Low income parents who are uninsured have significantly reduced rates of health care use than insured parents.[41]
- Children of teen mothes visit medical providers less than children born to older mothers (3.8 times vs. 4.3 times).[42]

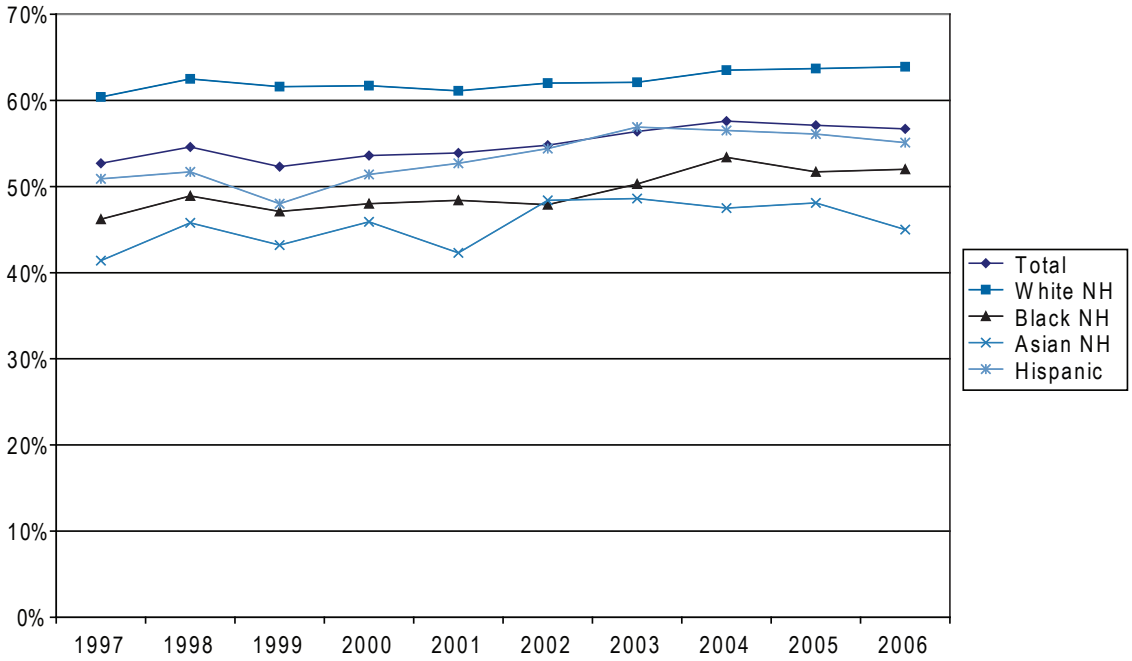
Risk factors for late or no prenatal care include: under age 18; unmarried; low educational attainment; a member of a racial or ethnic minority.[45] At-risk populations, such as adolescent mothers and their children, receive greater positive benefits from prenatal care than other populations.

By 2006, almost 60% of pregnant teens in New York State received prenatal care in the first trimester; however, more than 10% did not start prenatal care until the third trimester or not at all. When viewed by racial or ethnic group, White non-Hispanic mothers had the lowest rate of late care; Black non-Hispanic, Hispanic and Asian non-Hispanic mothers were all above the state average.



This chart shows by race and ethnicity the percentage of teen mothers in New York, between 1997 and 2006, who received late or no prenatal care, that is, those who did not receive care until at least the third trimester. White, non-Hispanic mothers had the lowest rate of late entry into prenatal care while Black, non-Hispanic teens entered late care at almost twice that rate. ***Source:*** *NYS Department of Health*

Percent Early (1st Trimester) Prenatal Care by Race/Ethnicity



This chart shows by race and ethnicity the percentage of mother's age 15-19 who receive early prenatal care. There has only been a slight increase in the number of teen mothers who access early services in the past decade. ***Source:*** *NYS Department of Health*

Low Birth Weight

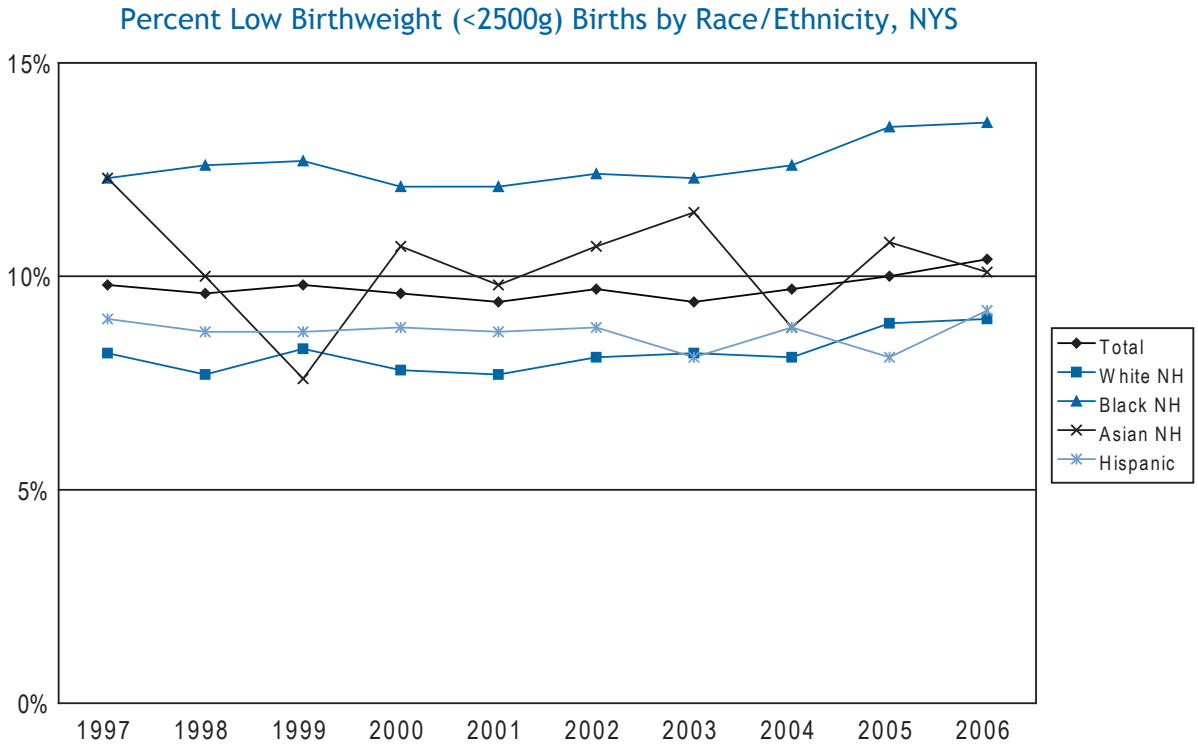
Low birth weight (LBW) babies are those whose weight is lower than it should be for full gestational age. Babies considered LBW are born under 2,500 grams (5 pounds, 8 ounces). States have found it difficult to continue to reduce LBW births because of the complex medical, social and economic issues involved. Prematurity is associated with significant hospitals costs that decrease exponentially as the gestational age increases.[46] In one study, neonatal costs were just under $10,000 per case for infants born between 2,000 and 2,500 grams. Cost rose dramatically for infants born at lower weights.[47]

LBW newborns are at high risk for a variety of physical, developmental and cognitive disabilities. Many will require extensive hospitalizations and suffer life-long disabilities. In addition to the human cost, there are substantial health care costs since LBW babies account for 10% of all pediatric medical costs.[48]

Younger mothers are at high risk of LBW births but research is unclear if this is the result of biological/ medical factors (inadequate health care, poor diet before the pregnancy or physical immaturity) or behavioral factors (smoking, alcohol or substance abuse before and during the pregnancy).[49]

In New York, 8.3%, or 1 in 12 babies born to women of all ages in 2006 were LBW.[50] For teen mothers, the rates are higher – ranging from 9% for White teens to 13.6% for Black, non-Hispanic teens. The average across the state was almost 10%. Interventions have been proven to make a difference:

- Among very young adolescents (ages 14 – 16), those who were visited by a nurse had babies who were 395 grams heavier than the control group.[51]
- According to research done by the Healthy Families New York Program, among teens under age 19, those assigned to an intervention group at or before 30 weeks of pregnancy had babies who were 201 grams heavier than the control group. They were also almost five times less likely to give birth to a LBW baby (3.5% to 13.6%).[52]



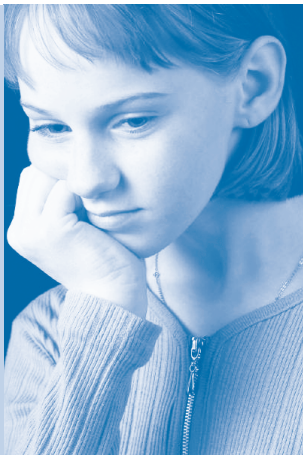
This chart shows by race and ethnicity the percentage of low birth weight children born to New York mothers, ages 15 to 19. Between 1997 and 2006, children born to black, non-Hispanic mothers were more likely to be low birth weight than children born to other mothers.
Source: *NYS Department of Health*

Mental Health

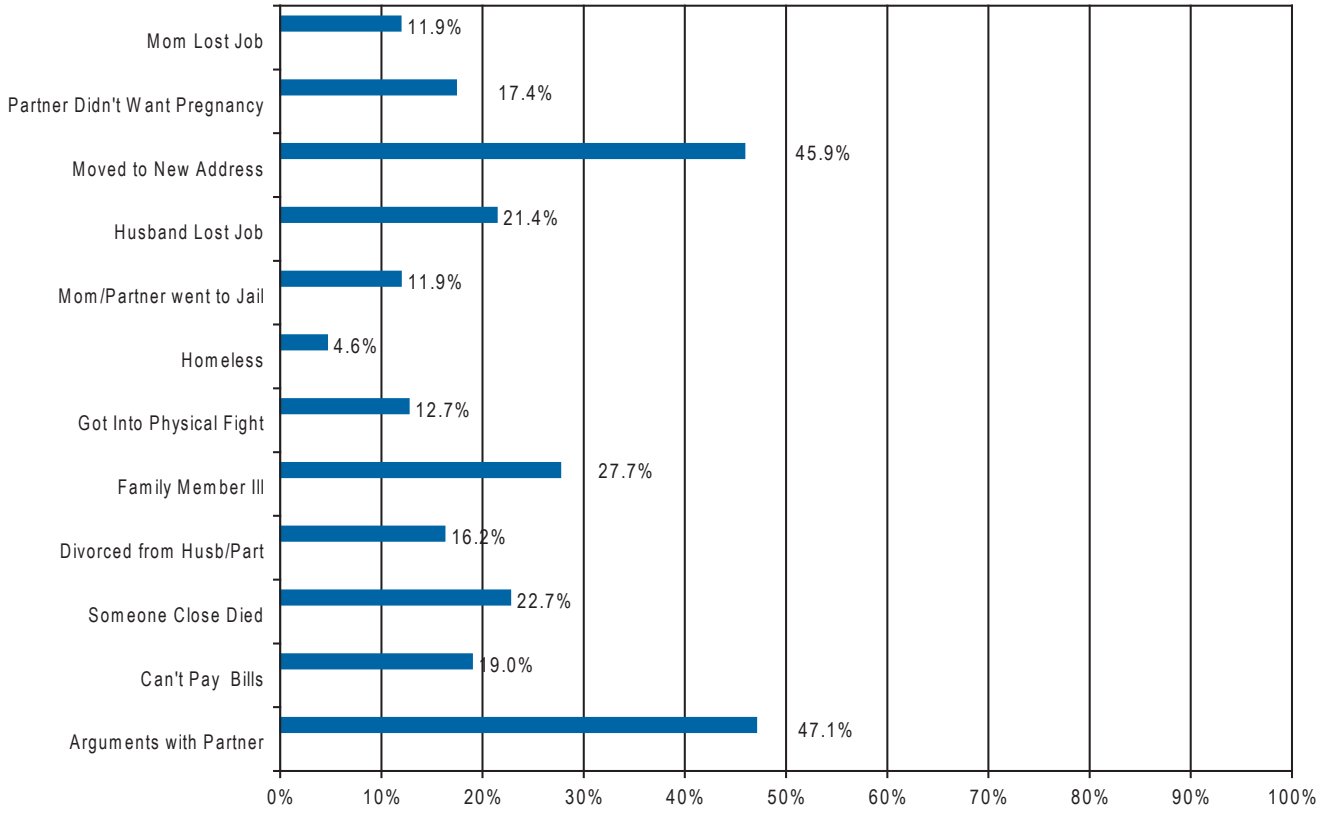
The importance of adolescent mental health has often been overlooked by the medical community, educators, policymakers and even parents. An estimated 40,000 youth between the ages of 14 – 18 receive inpatient or outpatient mental health treatment in any given year in New York State[53] but evidence suggests that many more remain undiagnosed or untreated. Adolescent motherhood can increase the risk of mental health problems, including depression that reduces the ability to form attachments, interferes with attentiveness and nurturing, and results in disengagement from the child.[54]

Stress can also take a toll on a teen mother and her children – physically, mentally and emotionally. For example, one study found that high levels of hormones produced when under stress were associated with lower fetal weight.[58] Data from the New York State Pregnancy Risk Assessment Monitoring System (PRAMS) data base show that teen mothers suffer from a number of stress factors including relocation, arguments with partner, physical altercations, and death or illness of family members.

- While almost half of teen mothers in New York State reported few mental problems during their pregnancy, over one third experienced mild to significant problems.[55]
- As many as 48% of adolescent mothers experience depressive symptoms as compared to 13% of adult mothers.[56]
- Depressive symptoms in teens following birth increase the risk of subsequent pregnancy.[57]



Stressful Events During Pregnancy as Reported by Teens, PRAMS 1998-2006



This chart shows stressful events reported by New York teens during their pregnancy for the years 1998–2006 inclusive. ***Source:*** *NYS Department of Health*

Family Stability

Stable family and social relationships are critical to ameliorating some of the accumulated disadvantages – greater risk for poor economic, health and educational outcomes – associated with teen mothers and their children. Family stability and support has a great influence on the health and welfare of the mother and the child.

Homelessness

Five percent of all teen mothers reported that they were homeless at the time they gave birth.[59] In New York, over 1,252 teens with 694 children sought shelter in a facility for runaway and homeless youth in 2005.[60]

Research on households headed by teenage mothers living in homeless shelters in New York City revealed similar troubling statistics:[61]

- In 2003, almost half of homeless heads of household in shelters were teenage mothers. One third were homeless before age 18 and 42% had been homeless more than once.
- 41% of the teen mothers in homeless shelters were removed from parental care; 39% witnessed domestic violence as a child and 25% were abused as children. A little over half were born to teenage mothers themselves.

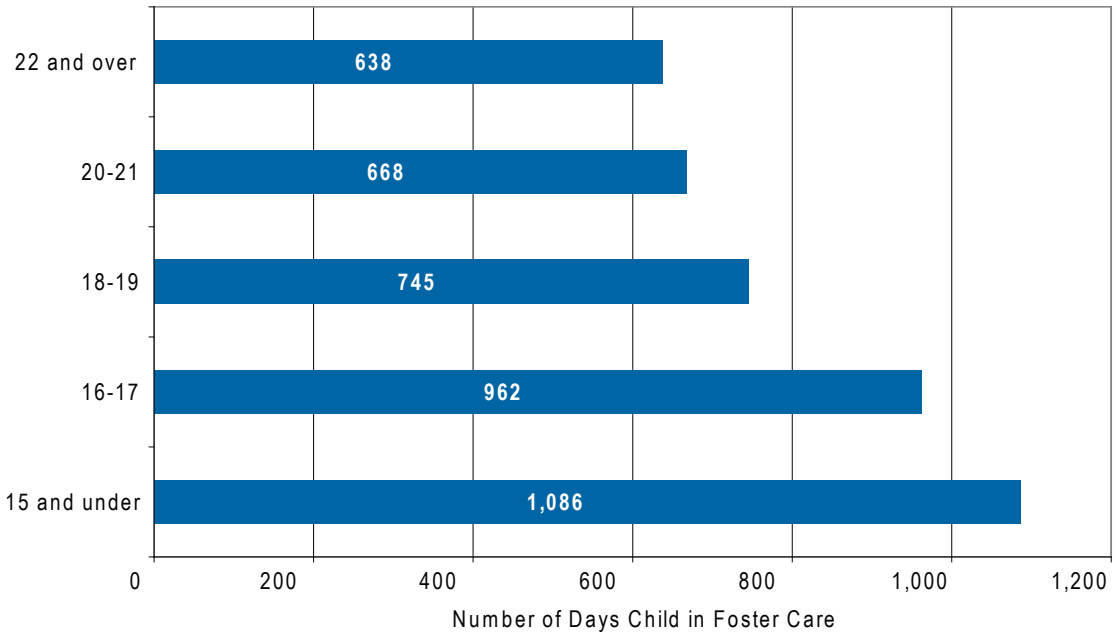
- Children born into homeless families headed by teen mothers were three times more likely to be homeless more than once (17% vs. 6%); the children were 60% more likely to be removed from parental care (16% vs. 10%), and virtually none of them received any emotional or financial support from their absentee fathers.

Young women and their children in the shelter system are without the supports necessary to keep them in either their parents' homes or their own. They most likely left those homes due to conflict, domestic abuse, or poverty. Once homeless, every effort must be made to reconnect these young mothers with the social services necessary to get them back on their feet and, maybe more importantly, connected to a caring adult who can lend support.

Child Welfare

The consequences of an unstable home life are evident in data around teen births to girls in foster care. Teens in foster care are likely to suffer from maltreatment; in addition, once teens "age out" of foster care at age 18, there are few supports available to them. It is estimated that teen childbearing costs the child welfare system $2 billion a year.[62]

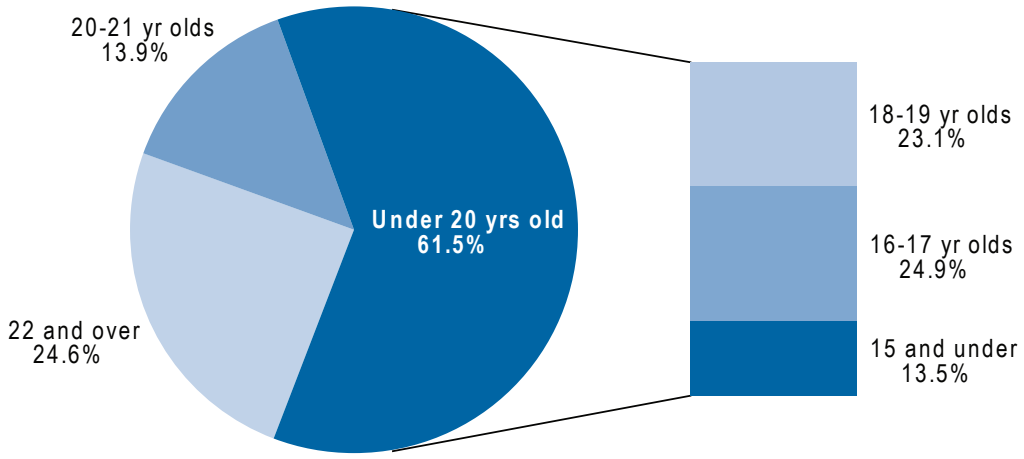
Duration of First Placement Spells by Age of Mother at First Birth
1982-2003



This chart shows the number of days that a child is in foster care for the first time by the age of the mother when she had her first child. US data. ***Source:*** *Chapin Hall Center for Children*

- Adolescents in foster care and those who age out are at increased risk of pregnancy compared to their peers.[63]
- Nearly one-third (32%) have at least one child, and half of 21-year-old men aging out of foster care report impregnating someone compared to 19% of their peers.[64]
- Children of mothers ages 18-19 are almost 40% more likely to have a reported case of abuse or neglect than children born to mothers ages 20-21.[65]
- Children born to teen parents are more likely to enter foster care or have multiple caretakers throughout their childhood.[66]

First Placement of Child in Foster Care by Age of Mother at First Birth
1982-2003



This chart shows the breakdown of children placed into foster care for the first time by the age of the mother. Mothers under age 15 through age 19 account for over 61% of placements. US data. ***Source:*** *Chapin Hall Center for Children*

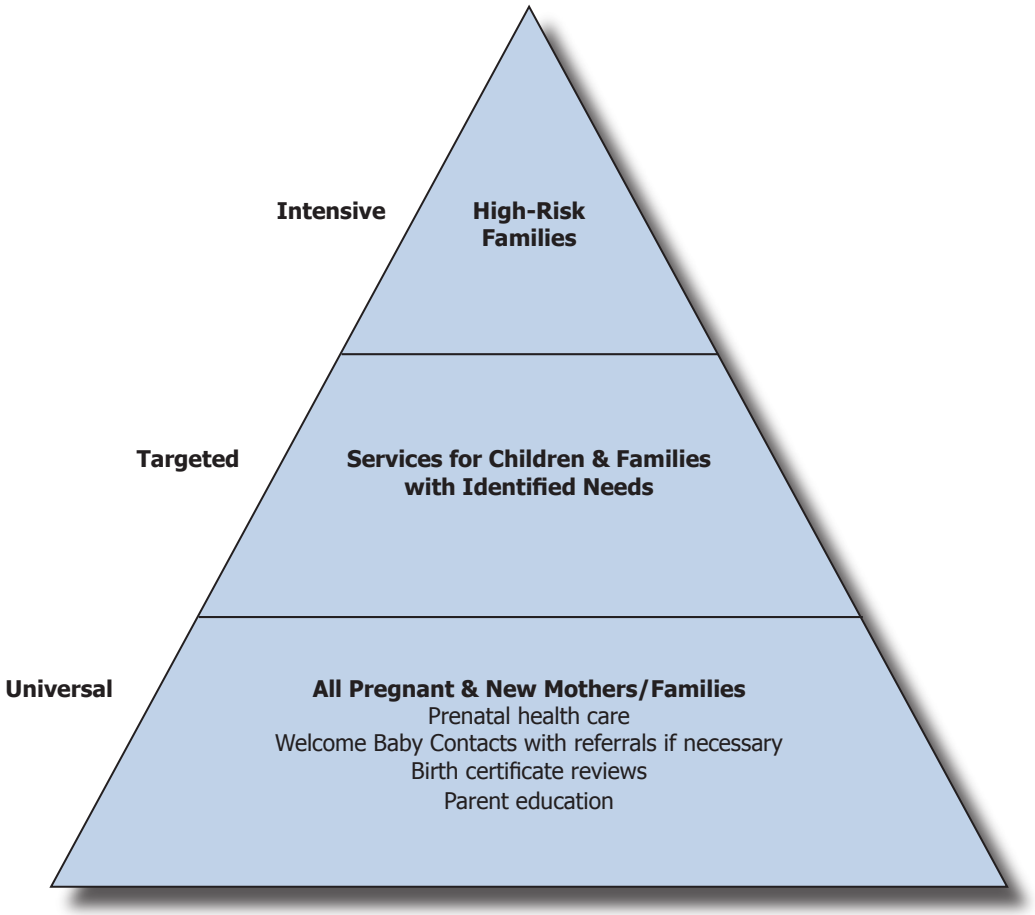
Expanding Interventions That Work

There are proven primary prevention programs to reduce teen pregnancy and programs that improve the outcomes for teen mothers and their children but none of these have been implemented on a large scale.

One significant service proven to reduce teen pregnancy is availability and use of contraceptives. A 2006 study attributed 86% of the decline in the US teen pregnancy rate between 1998 and 2002 to improved contraceptive use.[67] Other developed countries that have seen an increase in the availability and use of contraceptives have shown similar declines in adolescent pregnancy rates.[68] While 50% of adolescent pregnancies occur within the first 6 months of initial sexual intercourse, adolescents reported delaying seeing a clinician for a contraceptive prescription for a year after they became sexually active.[69] It is critical for teens to have accurate knowledge about sexuality and contraceptive use as well as access to necessary health services.

- Adolescents who as children were enrolled in preschool or child care programs that focused on improving education among disadvantaged children have fewer pregnancies and births than those who were not enrolled in such programs.[70]
- Programs that combine a focus on youth development (including involvement in such activities as educational mentoring, employment, sports, or the performing arts) with sex education can have a strong impact on frequency of sex as well as pregnancies and births.[71]
- Mentoring has been shown to have positive effects on teen mothers. Adult mentors can teach parenting skills and offer emotional support to pregnant and parenting teens.[72]

Home visiting programs specifically focus on families who are expecting or have new babies. They work with those families in their homes by providing direct services or assessing need, connecting families with appropriate services and monitoring ongoing well-being.[73] Home visiting programs provide assistance in the areas where teen mothers require assistance: improving parenting skills, social- emotional development and physical and mental health. These programs help prevent child abuse and neglect and improve birth outcomes (including increasing the spacing between pregnancies). Children in these programs do better in school, have fewer behavioral problems and higher high school graduation rates than similar children who were not enrolled in a home visiting program.[74]



Universal: Home visiting services for all expectant and new mothers/families. Program techniques are based on promising practices or on research-/evidence-based practices.

Targeted: Services for children and families with identified needs, such as mental illness, substance abuse, speech and language issues, or physical disability. Program techniques are based on promising practices or on research-/evidence-based practices.

Intensive: Services for families and children at high-risk for issues such as abuse and neglect, homelessness, and poverty. Teen parents also fall into this category. Programs must be evidence-based.*

*Evidence-based programs are defined as those that have the following characteristics:

- a specific model, curriculum, or protocol in implementation;
- specific written materials that set out components and goals of the practice protocols;
- a description of intensity and frequency of services, including program outcomes;
- a description of educational requirements of home visiting, ongoing training, support and supervision; and
- data documenting a statistically significant impact on the stated goals and desired outcomes.

Source: *Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State, Schuyler Center for Analysis and Advocacy*

- Children of mothers who received weekly, prenatal home-visiting, relationship-based interventions were found to be more secure, autonomous and task-oriented.[75]
- Having nurses visit the homes of pregnant women resulted in reductions in maternal cigarette smoking and improvements in diet during pregnancy, along with reduced rates of preterm delivery among women who smoked.[76]
- Programs where a nurse visits expectant and teenage mothers in their homes for more than two years have been found to lower the likelihood of those mothers having more children.[77]
- Children whose mothers received home visits from nurses had reduced rates of injury, ingesting dangerous substances and being victims of abuse and neglect than control group children.[78]
- 57% of participants in the Healthy Families New York program who were under age 21 at intake, without a high school degree or GED, are enrolled in a degree-bearing program or have received a high school degree or GED by the child's first birthday.[79]

In New York State, evidence-based, prenatal-early childhood home visiting programs serve approximately 15,000 young children and their families, fewer than 10% of children born annually, through a patchwork of funding.[80] Counties use a combination of child welfare preventive money and Article VI (State Aid to Cities and Counties) money to fund community health workers and the Nurse Family Partnership (NFP) Program. Only Healthy Families New York is state-funded, while Early Head Start is federally-funded. Other programs, such as the Parent-Child Home Program and Parents as Teachers, rely primarily on foundation funding. The current models are limited in scope by their own eligibility requirements, lack of financing, and geographic issues. Inconsistent integration between programs means that needy families may not qualify for services. And a lack of funding means that too few programs exist in the state to meet even the needs of those who do qualify.

SCAA has already proposed a solution to connect existing programs through a comprehensive system that would provide home visiting supports to all pregnant women and new mothers. The report, *Universal Prenatal/Postpartun Care and Home Visitation: The Plan for an Ideal System in New York State,* details the steps it will take for New York to achieve a high-quality, comprehensive home visiting system that includes services for parents at every level of need. (Full report available at www.scaany.org)

Conclusion

The data and information in this paper clearly shows the complexity of the causes and consequences of teenage childbearing. While it is generally acknowledged that teen mothers and their children are more likely to live in poverty and require various forms of public assistance, the broader effects on their lives is not always understood.

When viewed across the spectrum of life, the consequences of teen births are staggering. Just the lost potential of the mothers and children coupled with the amount of money expended on health, mental health, child welfare, food and nutrition programs, economic security and numerous other programs cut significantly into state resources. According to one analysis, teen childbearing cost New York State $421 million in 2004 alone.[81]

Then there are the human costs: children suffering from abuse and neglect, children born with physical or developmental problems because they were LBW, children who grow up at an increased risk of incarceration or of becoming teen parents themselves. There are also the mothers who quit school and remain in low wage jobs and the fathers whose earnings never reach their potential because they started paying child support so early in their own lives.

Research suggests that there are no quick fixes. The characteristics of the teens that fall into the pattern of teen births mean they are probably the hardest to reach and those more deeply entrenched in a culture and a reality of teens having children. There is additional urgency now because researchers are concerned that the rate of teen births nationally may be on the rise, and the emerging economic downturn might lead to further increases because of the relationship between childbearing and poverty.[82] The New York State Department of Health has recognized the importance of the issue by including a reduction of births to teens age 17 and under as an indicator in their guide to improve the health status of New York, *The Prevention Agenda: Toward the Healthiest State*.

New York must make a significant reduction in the teen birth rate a priority both for the well-being of children and families and to achieve cost-savings across any number of government-supported services.

Our overarching recommendation toward achievement of this goal is for New York State to create a cross-systems workgroup, charged with the responsibility to set quantifiable, date-specific targets to address teen pregnancy and its consequences for families and society. We suggest a number of immediate steps for the workgroup's consideration:

- Collect and coordinate New York State-specific data in a number of areas to inform policy making.
- Implement evidenced-based prevention programs, including access to family planning services, home visiting, youth development and parental education programs.
- Ensure adequate investment in coordinated interventions that provide the best services to teens who do become pregnant and their children.

It is prudent to start now to develop a comprehensive plan. This would allow the state to identify steps that can be taken immediately to coordinate services, gather data and improve communications among agencies. Through these efforts, New York can be ready to implement proven prevention and intervention strategies as soon as the economic situation allows new investments in programs.

Tackling yet another public policy issue is a challenge under any circumstances, and more so given the current economic environment. However, the number of teen births will not decrease without intervention, and will continue to drive substantial costs to the entire health and human service system.

Appendix A

Descriptions of Pregnancy Prevention Programs in New York State

Information supplied by the New York State Department of Health

Community Based Adolescent Pregnancy Prevention Program (CBAPP)

Purpose: In areas with high pregnancy rates among teens, the Community Based Adolescent Pregnancy Prevention Program (CBAPP) Program seeks to provide comprehensive adolescent pregnancy prevention activities to promote abstinence and delay the onset of sexual activity among youth, promote preventive health practices, and ensure access to comprehensive reproductive health services.

Populations Served: CBAPP serves 26 communities statewide, primarily in zip codes with the highest teen birth rates. The program serves adolescents from age 10-19, with a primary focus on 14-18 year olds. Communities served are ethnically and racially diverse including a broad representation from immigrant populations. A focus does exist on communities experiencing the highest rates of health disparities, specifically Hispanic and Black populations as demonstrated by higher adolescent pregnancy and birth rates.

Services Provided: There are three primary program strategies:

1. Promote abstinence and delay the onset of sexual activity among adolescents through the provision of comprehensive, age appropriate, evidence based, and medically accurate sex education;

2. Expand educational, recreational, vocational and economic opportunities for teens to provide alternatives to sexual activity and to develop skills that can lead to higher earning power and reduce the need for public assistance; and,

3. Ensure access to comprehensive family planning and reproductive health care services to prevent pregnancies, sexually transmitted infections (STIs) and HIV.

Funding: $6,926,664 in funding for 26 community-based contractors

Adolescent Pregnancy Prevention and Services Program (APPS)

Purpose: Teenage childbearing often interferes with the acquisition of development assets necessary for an adolescent to successfully transition to adulthood. In addition to an impact on the physical/emotional health of the adolescent mother or father, there is also a significant impact on their child and society.

The Adolescent Pregnancy Prevention and Services (APPS) Program works to address four statewide outcomes that are adolescent pregnancy prevention, coordination/community awareness, self-sufficiency, and health child development.

Populations Served: APPS serves 26 communities statewide, primarily in zip codes with the highest teen pregnancy and birth rates. The program serves adolescents from age 10-21 who are at risk of becoming a parent, are pregnant, or are parents, regardless of income. Programs serving communities that previously had high teen pregnancy and birth rates, but no longer meet this criterion, may receive funding to maintain these efforts.

Services Provided: Funding is provided to 26 community based organizations to coordinate existing services and fill service gaps in communities with teen pregnancy rates in the top 20 percent statewide. Services funded and available through referral by APPS vary across programs, depending on the unique needs of the target community, and fall into the following categories: Substance Abuse, Legal Assistance, Mental Health, Parenting Skills, Peer Relationships, Physical Health, Finances/Income, Recreation, Housing, Child Support, Child Care, Education, Employment, Family Planning, and Family Relationships.

Funding: $7,320,000 in funding for 26 provider contracts and one data contract.

Teenage Services Act (TASA)

Purpose: The Teenage Services Act (TASA), enacted by Chapter 975 of the Laws of 1984 (18NYCRR 361) requires local Department of Social Services (LDSS) to provide case management services to public assistance eligible pregnant or parenting adolescents. Since 1986, the program has been provided in New York as an optional Medicaid (MA) state plan service.

- TASA Comprehensive MA Case Management (CMCM) is the only county-wide program targeted specifically to Medicaid eligible teenagers to further access to pregnancy prevention and other services and supports required to maximize the teen's independent functioning in the community.

Population Served: TASA serves any teenager under 18 years of age who is a recipient of public assistance and is a parent residing in the same household with his or her child(ren), or is pregnant. Local social services districts may provide case management to any male or female adolescent who is over 18 and 21 years of age who is a public assistance recipient and is deemed to be at risk of pregnancy or parenthood based on at-risk criteria.

Services Provided: Funding is provided to twenty eight (28) counties and New York City with thirty seven (37) community-based organizations TASA case management services include intake and screening; assessment and reassessments; service planning and coordination; implementation, monitoring and follow-up of case management services, including access to crisis intervention; and, counseling and program exit planning. TASA administration varies by county; services may be provided directly by Local Department of Social Services (LDSS) staff or through CMCM contracts with community-based provider organizations. Local Districts refer potential clients to the provider agencies. In some instances, an agency may identify and refer clients to the LDSS for approval to participate in the program.

Funding: $5,582,409 in funding for twenty eight (28) counties and New York City with thirty seven (37) community-based organizations.

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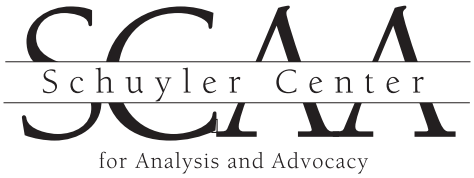
Notes



Schuyler Center for Analysis and Advocacy
150 State Street, 4th Floor
Albany, NY 12207
Tele. 518-463-1896
Fax 518-463-3364
www.scaany.org