



***LITERATURE REVIEW***

***POVERTY, HOMELESSNESS  
AND TEENAGE PREGNANCY***

**February 2006**

*Prepared for:* **First Steps Housing Project, Inc.**  
Saint John, NB

*Prepared by:* **Evaluation Designs Ltd.**  
Fredericton, N. B.

Funding for this Literature Review was provided by  
First Steps Housing Project Inc.  
Saint John, NB  
Canada

Author of the Literature Review:  
Tim Dilworth  
*Evaluation Designs Ltd.*  
Fredericton, New Brunswick  
Canada E3B 4H7

---

Principal:  
Carole Dilworth  
*Evaluation Designs Ltd.*  
Fredericton, New Brunswick  
Canada E3B 4H7

---

General enquires regarding this report should be directed to:

**Sharon Amirault**  
Executive Director  
Tel. (506) 693-2228  
Email: [firststeps@nb.aibn.com](mailto:firststeps@nb.aibn.com)

First Steps Housing Project Inc. and *Evaluation Designs Ltd.* © 2006.

**Introduction**

This Literature Review was undertaken at the request of *First Steps Housing Project Inc.*, Saint John, New Brunswick. It offers a comprehensive overview of the published literature on the topics of teen pregnancy, poverty, homelessness, effects of teen parenting and of poverty on child development, effects of childhood abuse and the societal and financial costs of “doing nothing”. Primary sources of literature were used throughout: primarily journal articles accessed on-line through the Harriet Irving Library (UNBF) and articles by experts in their field sourced on the internet. Every attempt has been made to properly reference the literature. However, the reader is advised that in many instances the writing of the original author/s best expressed the issue and therefore, the paragraphs were incorporated only with minor editing for readability. References are found at the end of the discussion for each topic area. Because each topic area stands alone, there is some repetition of the findings between topic areas.



**Topic I. Influences on vulnerable teenage girls and issues of pregnancy and homelessness****Poverty**

The reason(s) why teenage women become pregnant or give birth are difficult to categorize. In the body of literature examined, it was reported that the rise in rates was due to the fact that more teenagers were sexually active, were using less contraception, or that there was an individual desire to become pregnant (1). The first two factors were borne out by the National Longitudinal Survey of Children and Youth (1998/99 and 2000/01) which estimated that 12% of boys and 13% of girls had sexual intercourse by ages 14 or 15. Poverty, school achievement, and self esteem were also factors which have been said to play a role (2). Research illustrated that the lack of opportunity and socioeconomic disadvantage significantly contributes to teen age pregnancy (3). Poverty "...can be both the consequences and the causes of teen pregnancy and childbearing" (4).

Teen pregnancy is highly correlated with living in poverty (1). Teens living in poverty were more likely to get pregnant than teens who do not, and furthermore, teen parents often had lower lifetime earnings, as well as more social problems throughout life (2, 4, 5, 6, 7, 8). Pregnancy rates were highest among teens from single-parent families who had experienced poverty. For these teens, motherhood represented an acceptable solution that would compensate for a life of psychological, moral, family and social hardship<sup>1</sup>.

The extensive literature review by Dilworth (1) suggested that statistically, young mothers face a life of poverty, have lower levels of education and have less opportunity in the workplace than non-parenting teens. She found that research on teen pregnancy prevention usually focuses on the negative aspects of being a teen parent. For example:

- *There is a close correlation between dropping out of school, early pregnancy, and poverty.*
- *Children of teenage parents are more likely to have problems and to become teenage parents themselves, thus perpetuating the cycle of poverty begun by a teenage birth.*
- *Teen mothers often find themselves to be undereducated, underemployed and underpaid, promoting a generational cycle of disadvantaged families.*
- *Early childbearing holds a risk of delaying emotional development, of high stress and potentially abusive environments, and of the reduction of life opportunities for both*

---

<sup>1</sup> And Choices: Keeping teenage mothers in school. Education Quebec and Banque Scotia.  
<http://www.gouv.qc.ca/cond-fem/pdf/nourris-a.pdf>

*mother and child.*

- *The costs of adolescent parenthood for society are numerous. The mother's education often is interrupted or terminated, leading to a loss or reduction in future earning power, and a life of poverty.*

Despite these findings, Dilworth (1) stated that many young parents will say their child had provided them with more joy than they have ever known.

Teenage women who become pregnant and have children are frequently criticized, and their pregnancies get blamed for causing adult poverty, welfare dependence, and other social problems. Lee (9) found these reactions and beliefs to be unwarranted and ultimately, very harmful for a number of reasons. First, they obscured the very important fact that as a group these young women tend to be overwhelmingly poor even before they get pregnant. Second, these beliefs lead to the creation of policies that may punish teenage mothers when they are already facing the hardships that living in poverty brings. Third, they were harmful because they take attention away from the real issues that contribute to and exacerbate living in poverty – problems in educational systems, decreased labor market opportunities, the absence of reliable child care, inadequate housing, and the lack of health care. And finally, regardless of economic status, a number of teen pregnancies are the result of rape, incest and violence.

There are individuals and families who are particularly vulnerable to being persistently poor (10). Hatfield (11) demonstrated that one group in particular was vulnerable to long-term poverty – lone-parent families<sup>2</sup>. Long-term poverty (10) is multi-faceted:

- *Low-income individuals and families are often deprived of opportunities to develop their capabilities.* Having a lack of financial resources means that individuals and families have to make choices regarding the necessities of life. These choices may deprive individuals of opportunities to develop their capabilities. For example, children from lower-income families are not likely to have a computer at home and to participate in extracurricular activities (12). Women with lower incomes can't afford paid child care. Their major expenses are housing and food.
- *Low-income individuals are marginalized in the world of work.* Labour market attachment is usually weak among the poor. The persistently poor are likely to be unemployed or working part time (11). This may be due to lack of education or employment

---

<sup>2</sup> In *Low-Income in Census Metropolitan Areas, 1980-2000* by Andrew Heinz and Logan McLeod (22), there is a comparison of 27 Census Metropolitan areas (CMAs) with respect of groups at risk of being in low income. Overall in Canada, lone-parent families comprised 7.3% of the population, but 19.3% of the low-income population. More importantly, between 1980 and 2000, while the low-income rates in lone-parent families went down in all the 27 CMAs combined (54.2 to 46.6%), this was not the case in Saint John where there was no change (62 to 62.4%). The low-income rate for children for the 27 CMAs combined did not change for the same period (20.4 to 20.8%) or for Saint John (23.3 to 23.6%).

opportunities. Most importantly, for those who are employed, many become trapped in jobs that offer little security and low pay. Individuals in these precarious jobs are less likely to receive on-the-job training nor can they afford skills-upgrading courses that could help them get out of their predicament.

- *Low-income households are in need of adequate and affordable housing.* The poor are less likely to be able to afford quality housing, and as a result, are excluded from access to the quality services found in a well-provisioned neighbourhood, i.e., quality community services, schools, better infrastructure, and a vibrant community. Households with low attachment to the labour market and low income are more likely to have core housing needs (13)<sup>3</sup>.
- *Low-income people often lack the social capital, or networks, that are key to getting ahead in life.* Networks are very critical in enabling individuals to get by, and more importantly, to get ahead over the course of life. There are two kinds of networks: bonding networks that help individuals get by, such as close family and friends of the same social and economic background, and the more diverse bridging networks that can help individuals get ahead. The poor and socially excluded are strong in bonding networks, but weak in bridging networks (14).<sup>4</sup> While strong ties represented by bonding networks are essential, it is the weak ties mostly found in bridging networks that are critical, for example, in finding jobs and advancing one's career.

## **Education**

Young teen mothers have exceptionally low probabilities of completing their schooling, and thus, have poor employment prospects (15). Just over half of teenage mothers complete high school during adolescence and early adulthood. Many who complete high school do so with only an alternative credential – the General Educational Development (GED) certificate. Many of those who do complete regular high school have very low basic skills. The combination of low

---

<sup>3</sup> Engleland and Lewis (13), based on 2001 Census data, reported that lone-parent households had the second highest core housing need (42.3% of households) compared with all households at 15.8%. They also noted that 26.9% of lone-parent households were in what they termed high-need neighborhoods. These neighbourhoods had median incomes, on average, only half those of other neighbourhoods, unemployment rates nearly double that in other neighbourhoods, and the proportion of income derived from social assistance is twice that of other neighbourhoods.

<sup>4</sup> A study in the Olde North End found how important bonding networks were to the people in that neighbourhood. The young people have to leave the neighbourhood to attend high school where they face social exclusion. As a group, they “stick together”. Kids in the neighbourhood who are not being cared for by their parents are fed, clothed and looked after by others in the neighbourhood. It was brought up repeatedly that everyone knows everyone else, and friends look after friends and the children of friends. (Dilworth, C. and Dilworth, T. 2005. “Supporting Health in the Olde North End.” Prepared for the Olde North End Change Project, Saint John, NB by Evaluation Designs Ltd., Fredericton.

educational credentials, low basic skills, and parenting responsibilities means that teenage parents have limited employment opportunities and are restricted to the low-wage market.

The outlook for teen mothers who have educational deficiencies, sporadic work histories and other barriers to employment is not good. This population of young adults needs help in all areas of career preparation – academic and vocational education, employability and life skills development – if they are to overcome the difficulties that hinder their successful transition to adulthood. Given the educational, social, economic, and employment histories common among teenaged mothers, career development is a priority for helping them make the transition from adolescence to economic independence (16). These young mothers are also in special need of psychosocial development, life skills development, career awareness and job skills development.

Ettinger (17) listed a number of psychosocial factors that affect the education and training of teen parents: low self-esteem, low aspirations, motivation and expectations; unrealistic goals and ambitions; limited emotional resources for support and maintenance; and lack of role models. Ettinger suggested that attention be given to the development of the following types of life skills:

- Building of self-concept,
- Building support systems,
- Learning how to access available child care, transportation services and other support
- Services necessary to one's survival,
- Learning how to meet the challenge of combining work and family roles,
- Learning how to give and receive emotional support,
- Networking for work opportunities and connections, and
- Enhancing interpersonal communication and relationships.

### **Drinking, Drugs and Smoking**

Although it is difficult to prove that certain behaviours make teenage women more likely to become pregnant, the literature has suggested that there is a relationship between risk behaviours (drinking, smoking, and drugs) and the likelihood of becoming pregnant (1). Often those who are least well-prepared to nurture and raise a child are those most likely to become pregnant. These include young women with substance abuse problems, not doing well in school, who have low aspirations and who live in disadvantaged homes (18).

A Health Canada study (19) found that in one program surrounding teen pregnancy, 64% of the participants were smokers. In the LEAP (Lifestyle Education for Adolescent Parents) program (now Healthy Baby & Me) in New Brunswick, a significant number of the participants were also found to be smokers (20).

**Single Parenthood**

Over time, adolescent mothers have become increasingly likely to remain single parents, and thus, the sole providers for themselves and their children (21). Maynard found that most teen parents are unmarried five years after giving birth. Moreover, fewer than half of the teens who give birth married within the next 10 years (21). Marital status at the time of the first birth becomes a powerful predictor of subsequent poverty status and welfare dependence, regardless of the age of the woman when she has her first child. More than 66% of all unmarried child bearers ended up on welfare, as did 84% of young teen mothers who are unmarried when their first child is born. Especially notable is that when these teen mothers go on welfare, they tend to do so for long periods of time – more than 5 of the 10 years following the birth of their first child.

**Literature**

1. Dilworth, K. (2000). Literature Review (Teenage Pregnancy). Canadian Institute of Child Health.  
([http://www.phac-aspc.gc.ca/dca-dea/publications/reduce\\_teen\\_pregnancy\\_section\\_2\\_e.html](http://www.phac-aspc.gc.ca/dca-dea/publications/reduce_teen_pregnancy_section_2_e.html)).
2. Stewart, P. and Associates. (1998). Population health approach to the prevention of teen pregnancy: Research evidence for action. *In* Forming a Canadian Coalition on the Prevention of Teenage Pregnancy: Three Background Papers. Prepared by the Young/Single Parent Support Network for Health Canada.
3. Singh, S. and Darroch, J. E. (2000). Adolescent and childbearing: Levels and trends in developing countries. *Family Planning Perspectives*, 32(1), 14-23.
4. Kirby, D. (2001). Emerging answers: Research findings on programs to reduce teen pregnancy. Washington, DC: National Campaign to Prevent Teen Pregnancy.
5. Health Canada (1999). A Report from Consultations on a Framework for Sexual and Reproductive Health. Ottawa: Minister of Public Works and Government Services.
6. Planned Parenthood Nova Scotia. (1996). Technical Report. Halifax: Planned Parenthood and the Nova Scotia Department of Health.
7. Evans, L. (1998). Sexual health education: A literature review on its effectiveness at reducing unintended pregnancy and STD infection among adolescents. Montreal: Canadian Association for Adolescent Health.
8. Picard, L. et al. (1998). Teen prenatal study: Sudbury/Manatoulin and Algoma Districts. Ottawa: Health Canada through the National Health and Research Development Program (NHRDP).
9. Lee, J. (2004). Pregnant and parenting teens and poverty. *Woman View*, 8(5), 1-2.
10. Kunz, J. L. and Frank, F. 2004. Poverty, thy name is hydra. *Horizons*, 7(2), 4-8.
11. Hatfield, M. 2004. Vulnerability to persistent low income. *Horizons*, 7(2), 19-26.

12. Ross, D. and Roberts, P. 1999. Income and child well-being: A new perspective on the poverty debate. Ottawa: Canadian Council on Social Development.
13. Engeland, J. and Lewis, R. 2004. Exclusion from acceptable housing: Canadians in core housing need. *Horizons*, 7(2), 27-33.
14. Perri 6. 1997. Escaping poverty: From safety nets to networks of opportunity. Demos.
15. Maynard, R. A. (1997). The study, the context, and the findings in brief *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.
16. Lunkard, B. A. (1994). Career education for teen parents. ERIC Digest No. 148, ED376272, Columbus, OH: ERIC Clearinghouse on Adult Career and Vocational Education.
17. Ettinger, J. M. ed. (1991). Improved career decision making in a changing world: Integrating occupational information and guidance. Washington, DC: National Occupational Information Coordinating Committee. (ED 345 047)
18. BC Alliance. (1999). Fall newsletter. BC Alliance Concerned with Early Pregnancy and Parenthood and YWCA of Vancouver.
19. King, A. J. C, Boyce, W. F. and King, M. A. (1999). Trends in the Health of Canadian Youth. Ottawa: Health Canada.
20. Simpson, M. L. 1999. A LEAP in the right direction: Report on the evaluation of LEAP (Lifestyle Education for Adolescent Parents), Fredericton: VON New Brunswick Inc.
21. Jacobson, J., and Maynard, R. (1995). Unwed mothers and long-term welfare dependency In *Addressing Illegitimacy: Welfare Reform Options for Congress*. Washington, DC: American Enterprise Institute. September.
22. Heisz, A. and McLeod, L. (2004). Low-income in Census Metropolitan Areas, 1980-2000. 89-613-MIE, No. 001. Ottawa: Statistics Canada.

**Topic II. *Impact of poverty on the development of infants and young children***

The traditional progression from adolescence to adulthood has been education, job preparation and employment, marriage and parenthood. Contemporary teenage parenthood represents a variation in that traditional pattern and has been described as an “off-time” in the transition to adulthood (1, 2). Pregnancy eclipses childhood and adolescence, thrusting the teenage mother into a world of adult responsibilities. Many pregnant teens have not yet accomplished basic developmental tasks of establishing identity, developing the capacity of intimate relationships, meeting educational and career objectives, achieving economic independence and developing self-esteem (3). As a result, teen mothers are more likely than other mothers to live in poverty and rely on public assistance (4). The vast majority of children born to teenage mothers grow up in economically and educationally disadvantaged households. Clearly, children of teen mothers start life with more disadvantages than children born to older women. Research suggests that the costs of teenage pregnancy are primarily borne by the children of these young mothers.

**Low Birth Weight**

Adolescents are twice as likely to have low birth weight infants as mothers in their 20's (5, 6). Low birth weight babies are 40 times more likely to die during the first month of life as compared with babies of normal weights. In addition, health problems and birth defects are 39 percent higher in low birth weight infants. In 1995 in Canada, the rate of low birth weight was higher among non-married women (single and common-law) compared to married women (6.8% compared to 5.1%) (7). The increased incidence of poor outcomes, including low birth weight and preterm birth in lower socio-economic classes, has been very well documented (3). The impact of socio-economic status on birth weight overrides all other associated factors, including physiological, since most of the poor outcomes in the low socio-economic group are attributable to adverse environmental conditions (8). Rates of adolescent pregnancy and single parenthood, both associated with increased risk of low birth weight, are also much higher among the poor. Maternal smoking is the most clearly established preventable risk factor associated with low birth weight. This association has been shown in world wide studies encompassing half a million births (3). Women who continue to smoke in the prenatal period are more likely to be teenage, unmarried and have less education (9, 10). What increases the risk of low birth weight (3)?

SOCIAL RISK FACTORS	PERSONAL
<ul style="list-style-type: none"> <li>▪ Poverty</li> <li>▪ Single parent</li> <li>▪ Teenage parent</li> <li>▪ Little or no prenatal care</li> <li>▪ Living with a violent partner</li> <li>▪ Generally stressful life</li> <li>▪ Workplace conditions</li> <li>▪ Type and amount of work</li> </ul>	<ul style="list-style-type: none"> <li>▪ Smoking</li> <li>▪ Alcohol and other drug use</li> <li>▪ Poor nutrition before and during pregnancy</li> <li>▪ Limited stress-relief strategies</li> </ul>

Source: PEPEO, 1998

### School Readiness and Development

A long term study of Nova Scotia mothers and their children conducted by the Nova Scotia Department of Community Services (11, 12) examined the socioeconomic outcomes related to teen pregnancy and single parenthood vs. married parenthood. They assessed the children of mothers in their sample and found few differences between groups. The children of the younger mothers scored lower than those of older mothers in the area of verbal comprehension, but their general scores as a group were within the normal average range of scores for all children. Nor was there a significant difference in the ways the mothers in this sample dealt with child behavior.

The generally positive outcome of the children's development puts to rest a great deal of concern and speculation about how well children of unmarried teenage mothers develop compared to children born into two parent families. The study showed that mothers share similar experiences raising children (e.g., constraints on time and access to childcare). While differences occur, it is not because one group is more devoted but because of the circumstances in which the families live (11).

Other studies have found different results with respect to school readiness and development. One of these studies assessed the effects of early childbearing on the children themselves and looked specifically at four types of outcomes: the quality of the home environment provided to the child; the child's cognitive development and educational attainment; physical and psychological well-being; and behaviour problems and substance abuse (13). They considered these potential impacts for the children when they were young as well as when adolescents. In addition, they examined whether firstborns fared differently from their siblings.

Their major findings were in the areas of home environment and cognitive and educational development. When they controlled for the mother's background characteristics, the quality of the home environment (including both emotional support and cognitive stimulation) was over 4 points lower (on a normal scale where the mean is set at 100) for the children of teen mothers than for those of mothers at age 20 to 21. The children of teen mothers also scored lower in mathematics and reading recognition (4 points) and in reading comprehension (3 points) during all ages up to 14. These differences carried over into adolescence in the form of greater likelihood of repeating a grade and being rated unfavourably by teachers in high school. Birth order was not important as these deficits were found for subsequent children as well as the firstborn children of teen mothers.

Ross et al. (14, 15) reporting on the first round results from the National Longitudinal Survey of Children and Youth (NLSCY), found that the children from lone-parent families<sup>5</sup>, compared to all children, appeared to have slightly greater potential development problems. To determine just how well children in lone-parent families were faring compared to all children, the researchers looked at whether child in lone-parent families were over represented in the bottom 10 percent (decile) for the 55 different outcomes measured. If the percentage in that bottom decile was more than 25 percent higher than for all children, the outcome was considered significantly negative, i.e., poor outcome.

In almost 70 percent of cases, lone-parent children were over-represented in the bottom decile of all children. The primary differences noted were in health status, although there were no significant differences in long-term health outcomes, motor development, or social development. This team of researchers stated, "This strongly suggests that there are some factors associated with living in a lone-parent environment which prejudice child development." But "...it does not mean that lone-parenthood per se is the main factor, but that there is most likely a constellation of factors strongly associated with lone parenthood."

Based on their statistical examination of 30 distinct intervening and outcome variables (which combined for 55 age-specific variables) children of lone parents showed poorer outcomes in 38 areas. It is important to note that even in these 38 areas, the differences, while observable statistically, could not be described as outstanding. For the remaining 17 areas, developmental outcomes were indistinguishable between the lone-parent children and all children cohorts.

---

<sup>5</sup> Lone-parent families in the NLSCY include families of several types (teen, older, result of marriage breakup, mother or father, etc.) which explain some of the findings and must be taken into account in relating to teen mother families.

The developmental areas where lone-parent children seemed to fare relatively poorly were in behavioural outcomes involving variables such as hyperactivity, physical aggression, and emotional disorder. They also scored less well on the relationship measures, including whether they were getting along with friends or parents. Educational outcomes such as repeating a grade, receptive language skills, and their health, were other areas where lone-parent children performed poorly. However, when it came to their participation in extra-curricular activities, except for attending nursery school or participating in organized sports, there were few noticeable differences between the lone-parent and all children cohorts.

Ross et al. (14) found the same pattern in their comparison of the variable distributions of outcomes for each of the age groups: children aged 2-3 years, 3-5 years, and 6-11 years. The variable distributions, however, revealed that while there was some cause for concern regarding those lone-parent children who perform relatively poorly, there were still very large proportions of lone-parent children who perform quite adequately on the variables in each domain.

The NLSCY<sup>6</sup> provided good news as well: most single parents are doing a good job of raising their children, and most children of lone-parent families show no problems.<sup>7</sup> In general terms, all researchers, commentators and workshop participants were “pleasantly surprised” by how well the majority of lone-parent families were doing.

Where differences existed, they were related not to lone parenthood, but to a cluster of characteristics that were over represented among lone parents: low income, depression, lack of social supports, and the like. The first-round research focused on the “how” and “why” of problematic outcomes for children of lone parents, presumably in order to develop ways to remedy the problems. At the workshop, they decided collectively that it was important to study successful lone parents to learn what characteristics contribute to positive outcomes among their children.

Ross et al. (14) revealed the variation in outcomes that exist among lone-parent children, the points where their development patterns converge and diverge from the general child population. They found a wide variation within the lone-parent population for many of these variables, even on those variables where the distribution of outcomes among lone-parent children was skewed toward greater vulnerability. Moreover, this study pinpointed the specific areas where lone-parent children appear to be more vulnerable to negative long-term outcomes.

---

<sup>6</sup> Cycle 1, 1994-95

<sup>7</sup> Workshop 1: Family Structure of Investing in Children: A National Research Conference held in Ottawa in October 1998 reporting on the results of the first cycle of NLSCY research.

Ross et al. (16) sought explanations for the variation in outcomes for children in lone-parent families. Because many of these children were doing well, the researchers constructed an age-related vulnerability index to determine what characteristics were associated with better outcomes and what were associated with poor outcomes. They found that parents (usually mothers, in the survey) with higher educational status were associated with better outcomes, while parents suffering from depression were associated with poorer outcomes. Although 80 percent of the lone-parent households in the survey had low incomes, higher incomes were associated with better outcomes for children in two of the three age groups (2-3 years, 3-5 years, and 6-11 years).

They also found that consistent parenting led to positive outcomes, while a measure related to ineffective parenting was related to negative outcomes (16). The more ineffective the parenting style, the more vulnerable the child was and the more likely to see a cluster of poor outcomes. It was found that children of parents with stronger social supports were less vulnerable to problems.

Another study focused their research on the more than 80 percent of lone-parent families in the NLSCY survey that were led by mothers (17). They found what many other studies have shown: living in a mother-led family (even when controlling for income) put children at risk. They also examined other characteristics of the mother, including education level, emotional health, lack of social supports, and difficulties with parenting.

Children from lone-mother families were more likely to have difficulties in school, social problems, and psychiatric problems. The difficulties for these children rose with the degree of ineffective parenting, although most other difficulties were less prevalent when the data were controlled for gender, child age, maternal non-employment, maternal education, maternal depression, family dysfunction, and hostile and punitive parenting. In particular, their research reported that the combination of lone-mother status with ineffective parenting is particularly bad for children.

A study, based on the data from the NLSCY and the National Population Health Survey, examined 27 elements of child development that included family functioning, neighbourhood safety, aggression, health status, math and vocabulary scores, and participation in sports or clubs (18). They found that the level of family income plays a crucial role in the child development process, i.e., in 80 per cent of the variables examined, the risks of negative child outcomes and the likelihood of poor living conditions were noticeably higher for children living in families with annual incomes below \$30,000. This was also true for 50 per cent of the variables examined for children living in families with incomes below \$40,000 per year. For this analysis, the authors divided the child development process into six categories:

**Family**

- Children in low-income families were twice as likely to be living in poorly functioning families as are children in high-income families.
- Nearly 35 per cent of children in low-income families lived in substandard housing, compared to 15 per cent of children in high-income families.

**Community**

- More than one-quarter of children in low-income families lived in problem neighbourhoods, compared to one-tenth of children in high-income families.

**Behaviour**

- Nearly 40 per cent of children living in low-income families demonstrated high levels of indirect aggression (such as starting fights with their peers or family members), compared to 29 per cent of children in families with incomes of \$30,000 or more.

**Health**

- Children in low-income families were over 2½ times more likely than children in high-income families to have a problem with one or more basic abilities such as vision, hearing, speech or mobility.

**Learning Outcomes**

- More than 35 per cent of children in low-income families exhibited delayed vocabulary development, compared to around 10 per cent of children in higher-income families.

**Cultural and Recreational Participation**

- Almost three-quarters of children in low-income families rarely participated in organized sports, compared to one-quarter of children in high-income families.

A United States study (19) looked at five areas of school readiness between the children of teenage mothers and those of older mothers: 1) cognition and knowledge, 2) language and communication skills, 3) approaches to learning, 4) emotional well-being and social skills, and 5) physical well-being. The results showed that all seven cognition and knowledge skills were statistically lower for teen mothers than for children of older mothers even after controlling for family socioeconomic status, maternal marital status at birth and current family structure. Language and communication skills, upon kindergarten entry, for children of young teen mothers lagged behind children born to older mothers. Children of teenage mothers were less likely to read simple books independently and to demonstrate early writing ability. They also were marginally less likely to name all the letters of the alphabet and to demonstrate an understanding

of some of the conventions of printing. These children were less motivated to learn. They were more likely to be impulsive/overactive and exhibit internalizing problem behaviors and less likely to exercise self-control and demonstrate positive interpersonal skills. The results with respect to health and motor development were not as conclusive as to differences. This work showed that at least part of the reason children of teen mothers begin kindergarten behind in several areas is because of their family's social and lower economic status and a higher likelihood of being in a single-parent household.

### **Health and Medical Outcomes**

Wolfe and Perozek (20) compared the health of the children of teen mothers from birth to age 14 with the health of children of the same age born to older mothers. Health measures included whether or not the children were in excellent health, whether or not they were in fair to poor health, whether they had an acute condition, and whether they had a chronic condition.

The proportion of children reported to be in excellent health was substantially greater for the offspring of older mothers than the offspring of teen mothers. The children of older mothers were also somewhat less likely to be reported as in fair or poor health. On the other hand, the children of older mothers were more likely to have a reported acute or chronic condition than the children of teen mothers. This last result presumably is related to the fact that the children of the older mothers were older.

### **Abuse and Neglect**

A study by Goerge and Lee (21) used the Illinois State records to assess the impact of teen childbearing on child abuse and neglect cases and foster care placement. At the time that this study was done, it was one of the few data bases that provided detailed family information and the overall demographic characteristics of the Illinois child population was very comparable with those of the population in the United States.

The authors' descriptive statistics indicated that children born to young teen mothers are much more likely to be victims of abuse and neglect than those born to older mothers. New families in which the mother's age was under 18 at the time of first birth are also much more likely to become a case of child abuse and neglect than other families. Their unadjusted data also showed that once a child is in foster care, the duration of the foster care placement is higher for children of young teen mothers than for other children.

When birth order was controlled, it became apparent that subsequent children of mothers who bore their first child as a young teen were considerably more likely to be victims of abuse and

neglect that the firstborns of older mothers. When other demographic factors were controlled, the size of the differences between the children of young teen mothers and the children of older mothers was reduced, but the children of young teens were still considerably more likely to be victims of abuse and neglect and to be placed in foster care. However, the duration of time in foster care was no longer significantly different between the two groups.

### Literature

1. Lankard, B. A. (1994). Career education for teen parents. ERIC Digest No. 148. ERIC Clearinghouse on Adult Career and Vocational Education, Columbus, OH. <http://www.ericdigests.org/1195-2/teen.htm>.
2. Boxer, A. M. (1992). Adolescent pregnancy and parenthood in the transition to adulthood. *In* Early parenthood and coming of age in the 1990's. M. Roseheim and M. F. Testa (Eds.), Brunswick, NJ: Rutgers University Press.
3. Perinatal Education Program of Eastern Ontario (PEPEO). (1998). Prevention of low birth weight in Canada: Literature review and strategies. 2<sup>nd</sup> edition. Prepared for the Best Start Resource OPC.
4. Maynard, R. A., editor. (1997). Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. Washington, DC: The Urban Institute.
5. Tyree, C. L., Vance, M. B., and Boals, B. M. (1991). Restructuring the public school curriculum to include parenting education classes. Little Rock, AR: Arkansas State University.
6. Federal/Provincial/Territorial Advisory Committee on Population Health. (1999). Statistical Report on the Health of Canadians. Ottawa: Health Canada.
7. Nault, F. (1997). Infant mortality and low birthweight, 1975-1995. *Health Reports*, 9(3), 39-46.
8. Main, D. and Gabbe, S. (1987). Risk scoring for preterm labor: Where do we go from here? *American Journal of Obstetrics and Gynecology*, 157(4), 789-793.
9. Stewart, P. J. et al. (1995). Change in smoking prevalence among pregnant women 1982-93. *Canadian Journal of Public Health*, 86(1), 37-41.
10. Health and Welfare Canada. (1989). The active health report on alcohol, tobacco and marijuana. Ottawa: Canadian Government Publishing Centre.
11. Nova Scotia Department of Community Services (NSDCS). (1991). Mothers and children: One decade later. Halifax, NS: NS Department of Community Services.
12. Bissell, M. (2000). Socio-economic outcomes of teen pregnancy and parenthood: A review of the literature. *Canadian Journal of Human Sexuality*, 9(3), 191-105.
13. Moore, K. A., Morrison, D. R. and Greene, A. D. (1997). Effects on the children born to adolescent mothers *In* Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.

14. Ross, D. P., Roberts, P. A. and Scott, K. (1998a). Variations in child development outcomes among children living in lone-parent families. Ottawa: Applied Research Branch, Strategic Policy, Human Resources Canada. October.
15. Ross, D. P., Roberts, P. A. and Scott, K. (1998b). How do lone-parent children differ from all children? Workshop 1 (Family Structures), *Investing in Children: Ideas for Action*, National Research Conference. Ottawa: Applied Research Branch, Strategic Policy, Human Resources Canada. October.
16. Ross, D. P., Roberts, P. A. and Scott, K. (1998c). Comparing children in lone-parent families: Differences and similarities. Workshop 1 (Family Structures), *Investing in Children: Ideas for Action*, National Research Conference. Ottawa: Applied Research Branch, Strategic Policy, Human Resources Canada. October.
17. Lipman, E., Boyle, M. H., Dooley, M. D. and Offord, D. R. (1998). What about children in lone mother families? Workshop 1 (Family Structures), *Investing in Children: Ideas for Action*, National Research Conference. Ottawa: Applied Research Branch, Strategic Policy, Human Resources Canada. October.
18. Ross, D. P. and Roberts, P. (1999). Income and child well-being: A new perspective on the poverty debate. Ottawa: Canadian Council on Social Development.
19. Terry-Humen, E., Manlove, J., and Moore, K. (2005). *Playing Catch-up: How the Children of Teen Mothers Fare*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
20. Wolfe, B., and Perozek, M. (1997). Teen children's health and health care use *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.
21. Goerge, R. M. and Lee, B. J. (1997). Abuse and neglect of the children *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.



**Topic III. Abuse as a factor in causing homelessness of pregnant and parenting teens****Sexual Abuse**

It has been estimated that as many as 68% of teenage mothers have been sexually abused (1). Teenage mothers are more likely to abuse their children than older mothers (2), and if they themselves have been abused, they are significantly more likely to abuse their children than are teenage mothers who have no history of abuse (1).

Sexually abused teenage mothers generally have fewer support systems, experience more depression, and are more likely to abuse substances during pregnancy (3, 4, 5). Sexual abuse commonly results in lack of trust, low self-esteem and distorted ideas regarding sexuality, significantly impacting the ability to establish secure and lasting intimate relationships (6).

Family life appears to be related to adolescents' susceptibility to intra- and extra familial abuse and high-risk behaviors, including sexual activity and pregnancy. Similarities have been found between the family dynamics of sexually abused and pregnant adolescents, namely a patriarchal family structure, devaluation of the mother, and a daughter who takes on the maternal role (7). They also found that sexually abused females were more likely to become pregnant intentionally.

The risk of becoming pregnant is higher for some teenagers than for others. This is particularly true of teenagers who have been sexually abused. Sexual abuse can alter perceptions about sexual behaviour and influence judgment in forming intimate relationships, and thereby lead to earlier sexual debut, more sexual partners and an increased risk of sexual violence in intimate relationships (8). Sexually abused adolescents have experienced the violation of their most intimate boundaries, which can create a sense of powerlessness in relationships and may impair their ability to negotiate contraceptive use (9). As a result, sexually abused adolescents are less likely than their peers who were not abused to use condoms or other forms of birth control.

Methods of coping with abuse may also put a teenager at risk of pregnancy involvement. Two common results of sexual abuse are substance abuse and running away from home. Substance abuse before intercourse increases the risk of multiple partners and unprotected sex. Physiological changes in the brain as a result of the traumatic stress of sexual abuse make it more likely that abused teenagers who cope by using mood-altering substances will become chemically dependent, and they may turn to sex work to support their substance abuse. In addition, if the perpetrator is a family member, adolescents often attempt to escape the abuse by leaving home, living on the street and engaging in survival sex, or they may be placed in foster care or another out-of-home arrangement after the disclosure of the abuse. Runaway or out-of-

---

home youth, i.e., those who report living alone or living with foster parents or unrelated adults, are more likely to have a history of sexual abuse than any other youth. All of these behaviours have been linked to teen pregnancy involvement (10, 11).

### **Family Factors**

Disruption of parent-child relationships, conflict and abuse are not limited to families living in poverty. Sexual abuse of girls and young women occurs in families of all social classes. This may explain why family poverty is not strongly associated with homelessness among youth. There are indications, however, that family poverty is related to more chronic or repeated homelessness among youth (12).

Histories of family disorganization and disruption are characteristic of homeless youth. For example, a comparison of 563 housed high school students and 386 homeless youth in Toronto showed that the homeless youth more often came from families with unemployed members and divorced parents (13). Almost two thirds of the 360 homeless youth in another Toronto study reported that their parents separated during their childhood (14).

Kufeldt and Nimmo (15) reported that most of the homeless youth in their Calgary study left home because of family conflict and violence. Factors such as alcohol and drug use, mental illness and criminal behaviour, either on the part of youth or parents, have also been identified, but their causal relationships with homelessness have not been clearly established (16).

Perhaps the most studied aspect of the biographies of homeless youth has been family conflict and violence. Common sources of conflict with parents include friction over a youth's relationship with a stepparent, sexual activity and sexual orientation, pregnancy, school problems, and alcohol and drug use (12).

### **Maltreatment**

*I left home because my father was abusive, physically, sexually, mentally. I went through it for years; I blamed my mother because she wasn't there to protect me. I kind of blamed everybody even though my mother didn't know. I blamed her at the time, I was only a kid. That's why I started running. I was only twelve (homeless woman, aged 19, quoted in Gaetz et al. 1999: 10).*

There were 22,935 reports of missing or runaway females in Canada (57% of all reports) in 1994. Most of these young women left because of family conflict (17). The earliest study on homeless youth in Canada was the 1984 survey of 149 residents, aged 16 to 21, at a Toronto youth shelter (18). Almost three quarters of the young women had been sexually abused, either within their families or after leaving. Onset of sexual abuse came at an earlier age for females. Females were

---

more frequently sexually abused than males, and more severely. A caretaker was the usual perpetrator for females, while males cited caretakers and others equally. As with sexual abuse, physical abuse began at an earlier age for females and was more frequent.

The results of a subsequent survey at the same shelter showed that young women were more likely than young men to have initially left home before the age of 14. Sexual abuse of females was more often perpetrated by their fathers or stepfathers. In addition, females were more likely to experience violent sexual assault (16% vs. 9%), and rape (38% vs. 13%) (19). In comparison with a sample of high school youth, the shelter residents exhibited lower self-esteem, with females' self-esteem lower than males' self-esteem.

Very high levels of childhood abuse are a consistent finding in studies of street-involved and homeless youth. A Vancouver study (20) found that 71% of 110 homeless female teenagers reported a history of physical and sexual abuse, compared to 13% of a large provincial sample of students. Almost two thirds (63%) of the females in a Montréal study of 479 homeless youth had been sexually abused (21). Almost two thirds of the young women in another Montréal study characterized their fathers as menacing (22).

Conflict over young women's sexuality and parental attempts to control their daughters' sexual behaviour are common. Runaway girls interviewed by Schaffner (23) expressed hurt, anger and confusion over being called "whores" by their parents, a form of abuse not reported by heterosexual males. In a large U.S. study of more than 600 homeless youth aged 12 to 22, including 361 young women, found that twice as many girls as boys (regardless of sexual orientation) had left home or been kicked out because of a conflict with parents or caretakers about their sexuality or sexual behaviour (24).

It is also common for homeless young lesbians to have experienced conflict with their parents or other family members. Parental rejection may be as harmful as other forms of abuse. Growing up in a homophobic family is "by its very nature, a dysfunctional process" which may lead to developing a "false self" that often results in isolation and alienation from families (24).

Many young women have identified their histories of maltreatment as significant factors in their subsequent homelessness. Among the 360 homeless youth in a Toronto study, twice as many females as males cited sexual abuse as a key factor in leading to their life on the streets (40% vs. 19%). Females were also more likely than males to cite physical abuse as a factor (59% vs. 39%) (14). Among the 60 homeless young people aged 18 to 35 who were interviewed in a Montréal study, 92% attributed their homelessness and weak social network to instability and destructive circumstances in their original family situation (22).

---

**Consequences of Maltreatment**

Whitbeck and Hoyt (24) confirmed the existence of high rates of family disorganization, ineffective parenting, and physical and/or sexual abuse among homeless youth. Children with histories of maltreatment, with negative events in their own lives and those of family members, whose parents were rejecting or emotionally unavailable, and where there was high family conflict, were all at risk for depressive symptoms.

Several U.S. researchers explored the psychosocial consequences of maltreatment suffered by homeless youth. Schaffner (23) attributed young women's running away and the expression of anger, rebellion, disappointment, invalidation and powerlessness to a moral crisis of trust, extreme family conflict and the search for a safe authority. Adolescents who run away to escape sexual assault and physical brutality in their families have special emotional needs that set them apart from youth escaping overly strict parents or for other reasons. They have more severe separation problems, unresolved issues with their parents and difficulties in their post-runaway relationships (25). Adolescents who had been both physically and sexually abused within their families exhibited the most severe psychological problems and were at greatest risk for re-victimization (26).

Whitbeck and Hoyt (24) also reported that homeless young women who had been sexually abused by an adult caretaker were twice as likely as young men to be re-victimized. Gendered patterns of abusive relationships tended to be repeated. Young women who have been sexually abused by fathers or father figures are likely to reject mothers and mother figures and turn to men, especially young men, for solace and support (27). And children, especially boys, who have witnessed domestic violence, are more likely to use violent means to deal with conflict (28, 29). Without intervention, this gendered pattern continues to shape young women's relationships with men.

One of the important consequences of maltreatment for pregnant teenagers is stress. In an evaluation study of young women who were participants in the prenatal program (Special Delivery Club) of Healthy Baby & Me, the two most important factors causing the young women stress were identified as relationships with boyfriend/family followed by money (30). Abuse among homeless pregnant teenagers is most commonly from the boyfriend (87%) followed by family members, i.e., father, mother, uncle, stepfather, etc. (31).

The effects of family abuse are powerful. Young people with more abusive family backgrounds, tend to leave home at an earlier age and stay away from home for longer periods. Youth who have experienced serious abuse at home are drawn to each other. They are more likely to use

---

deviant survival strategies, experience street victimization and have depressive symptoms, including post-traumatic stress disorder (24).

Whitbeck and Hoyt (24) developed a risk amplification developmental model to account for the psychosocial patterns common among homeless youth. They determined that the negative effects of early psychological harm from coercive and abusive families are amplified through their influence on behaviours while the adolescents are on their own by increasing the likelihood of victimization. During a long process of increasing emotional separation from parents, adolescents become more involved with peers who provide information and support and help socialize them regarding street survival skills. The deviant social networks and high-risk behaviours increase the risk of serious victimization. As a result, these young people are assaulted and exploited within their new social networks. Re-victimization and aggressive or coercive social networks reinforce what they learned in their dysfunctional families. This process is very hard to reverse, and it affects young women more than young men. Attempts to force submission only reinforce their aggressive/coercive world view. Inevitable encounters with the legal system do the same; they institutionalize basic conflict in a continual power struggle over the adult status of homeless youth.

### Literature

1. Boyer, D., and Fine, D. (1989). Teen parent victimization: A preliminary report to the Department of Health and Social Services. Seattle, WA: Washington Alliance Concerned with School-Aged Parents.
2. Olds, D. L., Henderson, C. R., Tatelbaum, R. and Chamberlin, R. (1988). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 77, 65-78.
3. Stevens-Simon, C., and McAnarney, E. R. (1994). Childhood victimization: Relationship to adolescent pregnancy outcome. *Child Abuse and Neglect*, 7, 569-575.
4. Stevens-Simon, C., and Reichert, S. (1992). Sexual abuse, adolescent pregnancy and child abuse: A developmental approach to an intergenerational cycle. *Archives in Pediatric Adolescent Medicine*, 148, 23-27.
5. Donaldson, P. E., Whalen, M. H., and Anastas, J. W. (1989). Teen pregnancy and sexual abuse: Exploring the connection. *The Smith College Studies in Social Work*, 59(3), 289-300.
6. Kellogg, N. D., Hoffman, T. J. and Taylor, E. R. (1999). Early sexual experiences among pregnant and parenting adolescents – statistical data included. *Adolescence*, Summer, 293-304.
7. Butler, J. R, and Burton, L. M. (1990). Rethinking teenage childbearing: Is sexual abuse a missing link? *Family Relations*, 39, 73-80.
8. Raj, a. Silverman, J. G. and Amaro, H. (2000). The relationship between sexual abuse and sexual risk among high school students: Findings from the 1997 Massachusetts Youth Risk Behavior Survey. *Maternal and Child Health Journal*, 4(2), 125-134.

- 
9. De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment and policy. *Development and Psychopathology, American Journal of Orthopsychiatry*, 55(4), 530-40.
  10. Greene, J. M., and Ringwalt, C. I. (1998). Pregnancy among three national samples of runaway and homeless youth. *Journal of Adolescent Health*, 23(6), 370-377.
  11. Saewyc, E. M., Magee, L. L., and Pettingell, S. E. (2004). Teenage pregnancy and associated risk behaviors among sexually abused adolescents. *Perspectives on Sexual and Reproductive Health*, 36(30), 98-105.
  12. Robertson, M. and Toro, P. (1999). Homeless youth: Research, intervention, and policy *In Practical Lessons: The 1998 National Symposium on Homelessness Research*. L. Fosburg and D. Dennis (Eds.). Washington, DC: U.S. Department of Housing and Urban Development and the US. Department of Health and Human Services.
  13. Hagan, J. and McCarthy, B. (1998). *Mean Streets: Youth Crime and Homelessness*. Cambridge: Cambridge University Press.
  14. Gaetz, S., O'Grady, B. and Vaillancourt, B. (1999). *Making Money: The Shout Clinic Report on Homeless Youth and Unemployment*. Toronto: Central Toronto Community Health Centres.
  15. Kufeldt, K. and Nimmo, M. (1987). Kids on the street, they have something to say: Survey of runaway and homeless youth. *Journal of Child Care*. 3: 53-61.
  16. Hutson, S. and Liddiard, M. (1994). *Youth Homelessness: The Construction of a Social Issue*. London: Macmillan.
  17. Daly, G. (1996). *Homeless: Policies, Strategies, and Lives on the Street*. London: Routledge.
  18. Janus, M.-D., McCormack, A., Burgess, A. W. and Hartman, C. (1987). *Adolescent Runaways: Causes and Consequences*. Lexington, Mass.: D.C. Heath and Company.
  19. Welsh, L., Archambault, F., Janus, M.-D. and Brown, S. (1995). *Running for Their Lives*. New York: Garland Publishing.
  20. Peters, L. and Murphy, A. (1994). *Adolescent health survey: Street youth in Vancouver*. Murnaby, BC: The McCreary Centre Society.
  21. Régie Régionale de la Santé et des Services sociaux de Montréal-Centre. (1998). *Le « Défi de l'accès » pour les jeunes de la rue*. Montréal: Le Régie.
  22. Poirier, M., Lussier, V., Letendre, R., Michaud, P., Morval, M., Gilbert, S. and Pelletier, A. (1999). *Relations et représentations interpersonnelles de jeunes adultes itinérants. Au-delà de la contrainte de la rupture, la contrainte des liens*. Montréal: Groupe de recherche sur l'itinérance des jeunes adultes.
  23. Schaffner, L. (1999). *Teenage Runaways. Broken Hearts and "Bad Attitudes"*. New York: Haworth Press.
  24. Whitbeck, Les and Dan Hoyt. 1999. *Nowhere to grow: Homeless and runaway adolescents and their families*. New York: Aldine de Gruyer.
  25. Powers, J. and Jaklitsch, B. (1992). Adolescence and homelessness: The unique challenge for secondary educators. *In Education Homeless Children and Adolescents: Evaluating Policy and Practice*. J. Stronge (Ed.). Newbury Park, California: Sage Publications.

26. Ryan, K., Kilmer, R., Cauce, A. M., Watanabe, H. and Hoyt, D. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse and Neglect*. 24(3): 333-352.
27. Jacobs, J. L. (1994). *Victimized Daughters: Incest and the Development of the Female Self*. New York: Routledge.
28. Jaffe, P.G., Hurley, D. J. and Wolfe, D. (1990). Children's observations of violence: I. Critical issues in child development and intervention planning. *Canadian Journal of Psychiatry*. 35: 466-470.
29. DiPaolo, M. 1999. *The Impact of Multiple Childhood Traumas on Homeless Runaway Adolescents*. New York: Garland Publishing.
30. Dilworth, C. 2002. Program Participant Satisfaction. Section 1. Evaluation Report, Healthy Baby & Me Project, VON Canada New Brunswick Inc. Fredericton: Evaluation Designs Ltd. May.
31. Dilworth, C. and Dilworth, T. 2006. Proposal to The Minister of Family and Community Services, Province of New Brunswick. Prepared for First Steps Housing Project Inc., Saint John, NB. Fredericton: Evaluation Designs Ltd. February.



## **Topic IV. Residential Homes**

### **Introduction**

This topic summarizes the information found with respect to programs providing services and funding for pregnant and parenting teens including those who are homeless. It provides Canadian examples of residential homes and one Canadian drop-in program for pregnant homeless teenage women and several examples which are important such as St. Ann's Infant and Maternity Home (one of the earliest if not the earliest in North America) and Second Chance Homes in the United States. One program in Nova Scotia which provides support for homeless women is also included as 33% of their clients are in the 16-19 years age range. No programs in Canadian Provincial Departments were found although departments were not contacted directly. The residential programs which were found in Canada all had provincial and sometimes federal and municipal funding as well as monies from fund raising. A number of important papers on Residential Homes are reviewed under a section Maternity Residential Homes.

### **Canadian Examples of Residential Homes**

**St. Mary's Home / Maison Sainte- Marie (Ontario) (<http://www.stmaryshome.com/>)**

#### **Background**

St. Mary's Home, located in the east end of the City of Ottawa, is a private not-for-profit charitable organization. Since its establishment by Les Soeurs de la Providence in 1933, the home has provided specialized residential and community support services to high-risk pregnant and parenting women between the ages of 13-25 years, and their infants. The approach is holistic, grounded in a strong commitment to strengthen and build upon the personal resilience of each client.

The Home is the only licensed residential maternity home in Eastern Ontario. It accommodates 15 young women and 5 newborn infants at a time, and assists approximately 60 youth and their infants annually. Another 250 pregnant and/or parenting youth each year take advantage of community support programs at the Community Parent/Child Outreach and Program Centre which opened its doors in January 2002.

The building which houses the residential home was acquired by means of a pay-back loan from the Sisters of Charity. The Sisters of Charity continue to be supportive and take an interest in the Home and the Outreach programs. The residence is run by a 17-member staff, of which 10 are full-time. A Residential Director reports to the Executive Director who is responsible for both the Home and the Community Outreach Centre.

St. Mary's Home was innovative in being the first Maternity Home in Ontario to receive in-home private tutoring from the Ottawa Board of Education. This program which was later available through all area school boards until 1997, when the program was stopped by budget cuts. The Ottawa Carleton Catholic School Board's Immaculata High School has provided a satellite classroom for pregnant women in the St. Mary's Home Outreach Centre since the 1999-2000 school year where these young women can work on their school credits at their own pace. Many young women have been able to successfully achieve their dream of earning a high school diploma. Scholarships have been put in place to support their hopes of pursuing a post secondary education. Young women can stay registered with the School for at least six months after the birth of their baby while working on their parenting programs. This is the minimum amount of time that St. Mary's Home recommends for the initial mother-child attachment.

While pregnancy is the presenting concern which motivates a young woman to seek assistance at St. Mary's Home, other issues often compound her physical and medical needs, including: mental health difficulties, histories of sexual and physical abuse, addictions, developmental delay, or a history of family dysfunction related to violence. St. Mary's services and programs have developed over the years to encompass these issues and concerns.

**Mission Statement**

*Optimizing the future with pregnant and parenting youth and their children.*

**Our Commitment**

*St. Mary's Home is committed to providing comprehensive services, advocacy and programs for pregnant youth and young, single parent families. These are offered in a milieu of respect, care and safety.*

**Services**

The Services provided by St. Mary's Home include:

- Residence – Supportive group living for 15 pre- and postnatal young women
- School – The Ottawa Carleton Catholic School Board's Immaculata High School provides a satellite classroom for pregnant women within the Outreach Centre.
- Attachment Counseling – Provides Modified Interaction Guidance which is an intervention that promotes secure parent/child relationships.

- Counseling – Pre/Postnatal Support, Parenting Support, Young Fathers Support Counselor, Adoption Support, Advocacy and Outreach Support, Crisis Support, Addiction Assessment and Counseling, Community Referrals
- Teen Obstetrical Clinic – The Ottawa Hospital has partnered with St. Mary's Home to provide a youth friendly obstetrical clinic one afternoon a week.

**Programs***Independent Living Programs*

- Trusteeship Service
- LEAP Service – The Ontario Works Learning, Earning and Parenting program provides financial incentives and support to young parents so they can complete their high school education, learn to be good parents and to get jobs.
- Hands on Housing – This is a residential one-on-one program that helps individuals find a place they can call home when they are ready to be discharged from the residence.
- Housing Smarts – A program geared to help participants find and maintain housing for them.
- Spend and Save Smart – A program geared to helping participants get the most of their dollar and survive well on a tight budget.
- Live Smart – About learning how to manage housekeeping without becoming overwhelmed, developing routines and making a safe and warm home to enjoy living in.
- Independent Living Office Hours – Individual support from Independent Living Support Counselor.
- Collective Kitchen – A small group program that involves the participants making their meals for the week together.

*Parenting Programs*

- Baby Basics – Program to help young parents learn the ABC's of basic physical care and parenting of a newborn baby.
- Parenting Readiness – Helps you as a pregnant or new mom to prepare for being a parent.
- Parenting Workshops – Focus on Parenting Support, Child Development, Preventing Abuse, and on your children's Safety and Health needs.
- Parenting Styles – This program familiarizes a person with different types of parenting styles, identify for yourself the way you were parented and look at developing your own parenting skills.
- Right From the Start – Designed to help parents create a healthy loving relationship with their child

- 
- RAPP (Reading and Parents Program) – Teaches parents how to read to their babies in a variety of creative ways.
  - Young Father's Drop-in Program
  - It's My Child Too
  - Mom's Group
  - Mom's Only

### Financial Information

St. Mary's Home (not including the Centre) requires about \$700,000 a year to run, with about \$550,000 for an operating budget. Funds are received from federal, provincial and municipal governments, with the majority of operating monies coming annually in multi-year funding from the Ontario Ministry of Community and Social Services and the Ministry of Children's and Youth Services. They also receive funding from the United Way of Ottawa and the City of Ottawa.

In addition, the Board is in a continuous fund-raising mode with monies received privately from major foundations for designated projects. For example, a significant grant was received from the Ontario Trillium Foundation to help build the professional and organizational expertise of staff working in the Home. Ontario's Early Years Challenge Fund has also contributed \$715,089 over a three-year agreement for the development of the Parent/Child Outreach and Program Centre. In addition, St. Mary's administers the Health Canada funds and programs under the Community Action Plan for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) for the Ottawa region. A multitude of programs are now offered at this Centre.<sup>8</sup> Clearly, unlike New Brunswick, there are in this Province a number of avenues where St. Mary's can turn for funding.

**Villa Rosa (Manitoba)<sup>9</sup>** (<http://www.villarosa.mb.ca/>)

### Background

The Sisters of Misericorde founded a home for unwed mothers in Winnipeg in 1898. This facility operated until 1965 when a new facility was constructed on Wolseley Street, and renamed Villa Rosa. Though no longer operated by the Sisters of Misericorde, the home continues as a refuge for young, single women during and after pregnancy. The teens that make up their clientele have lived complicated tragic lives, similar to those who come to the door of **First Steps**, i.e., abuse by family members and boyfriends, substance abuse, and living on the streets and homeless. The Villa has 25 beds and a 9-suite apartment building, eight of which are for moms and their babies and one is for the night shift staff.

---

<sup>8</sup> <http://www.stmaryshome.com/programs.html> and face-to-face and telephone conversations with the Executive Director

<sup>9</sup> Telephone conversation with the Executive Director

**Mission**

*The mission of Villa Rosa is to provide educational, health and social services to young, single women and their families during and after pregnancy, in the Province of Manitoba. Programs are offered in a safe, nurturing environment that encourages personal growth and carried out in a fiscally responsible, culturally competent manner.*

**Services**

Services offered by Villa Rosa:

- assistance in connecting with appropriate medical professionals (midwife, obstetrician, physician, etc.)
- pre-natal classes and exercises
- labour preparation
- volunteer labour coaches
- nutrition counseling
- breastfeeding Support Program
- child development and parenting program
- in-house, individualized schooling by Winnipeg School Division #1 teachers
- self, cultural and spiritual awareness
- personal growth
- counseling
- support groups
- decision making
- anger management
- independent living skills and budgeting
- exploring adoption
- employment preparation
- career counseling
- awareness and use of community resources
- leisure activities: crafts, pottery, sewing, swimming, etc.

Villa Rosa's Community Outreach Program has an Outreach Social Worker which serves pregnant women and their families in their homes, based on referrals received through the women themselves and through hospitals and other agencies. The program is open to all residents of the City of Winnipeg and is completely voluntary. The Outreach Social Worker works

in conjunction with schools, Child and Family Services Division of the Department of Family Services and Housing and other parenting supports a woman may have and also serves as a liaison and advocate to help women access community programs.

The Villa Rosa Outreach Program offers:

- counseling
- crisis management
- support
- assistance with budgeting
- information on child development
- information on parenting issues
- support for effective parenting
- assistance in locating child care
- help with struggling relationships
- encouragement of good eating habits
- help for young moms to get back to school

### **Financial Information**

The core funding comes from the Provincial Government (approximately \$600,000 per annum) and the United Way (\$230,000 per annum). Combined, the funds from these two sources provide 70% of the 1.2 million dollars required to run the home. The agreement with the Provincial Government is for 3 years and for the United Way is 2 years. The final one third of the budget comes from fund raising and donations. The Villa has been trying to get federal funding but have not be able to secure any funds from that source as it has been in operation for a long time and federal funding is usually tied to new initiatives. They have managed to get some funding from the Supporting Communities Partnership Initiative (SCPI) and the Urban Aboriginal Strategy (UAS) – Homeless. Both these were through the Aboriginal Initiative.

**Massey Centre for Women (Ontario)**<sup>10</sup> (<http://www.massey.ca/>)

### **Background**

The Massey Centre provides housing and resources for pregnant teens, young single mothers, and their babies. After almost a hundred years in operation under a different name, the services were expanded and its name was changed in 1989 to The Massey Centre for Women. The

---

<sup>10</sup> Telephone conversation with the Executive Director

agency moved from simply a maternity home into a full resource centre for single mothers and their children. The home has always provided prenatal care to pregnant teens. In 1976, a postnatal unit was added and the services now include a secondary school program, subsidized child care, post-natal supportive housing project, and a residential complex of 27 units for mothers and babies. Presently, there is space for 76 moms and children, 48 spaces for day care, secondary school and a drop in centre for neighbourhood teens. The teens and their babies can stay at the Centre for 2 months and then move to an apartment and town house building managed by the Centre's administration.

### **Mission Statement**

The Massey Centre for Women is committed to improving the lives of disadvantaged young women and children. This is achieved through the following:

- A health pregnancy for young mothers and a healthy start in life for vulnerable infants.
- Emotional, social, life, and parenting skills development for young mothers, preparing them for independent living.
- The active promotion of normal early childhood development and prompt early intervention when delays are identified.
- Opportunities for young mothers to learn a variety of educational, social and vocational skills which will prepare them for community living.
- Supportive environments that promote individualized learning, improved levels of self-esteem, and the achievement of problem-solving and decision-making skills necessary for success.
- Education of society to increase awareness of the strengths and competencies of young mothers and their children.
- Education of society to increase awareness of the unique difficulties faced by young single mothers and their children.

### **Programs and Services**

*Prenatal Residence (Phase I):* This program is a group living setting with a capacity of 22 mothers and babies. The focus is on having a healthy baby, early bonding, taking care of a newborn, and learning the skills necessary for parenting and independent living. Each client must participate fully in her own "Plan of Care" which is designed by the client (with her worker) to meet her individual needs. This program serves approximately 65 clients each year.

*Apartment Program (Phase II):* The postnatal apartment program consists of 10 fully furnished, self-contained units. Each unit houses one mother and her baby. In this phase, clients continue to build life skills such as, cooking, cleaning, and budgeting. They continue to concentrate on learning positive and effective parenting skills. The young mothers go to school, take job training,

or work. Their babies attend the on-site day care centre. As with the prenatal program, the mothers are involved in the design of their individual plans and participate in them fully.

*Transitional Supportive Townhouse Program (Phase III):* This is the third and final phase of living at Massey Centre. There are 17 two-bedroom townhouses, each for one mother and baby. Basic rules and regulations still apply to clients living in the townhouses. The young mothers continue to work with their Phase II workers as they prepare for independent living. The mothers and babies continue to access all Massey Centre programs and activities. The apartment and townhouse programs serve approximately 55 clients each year.

*Secondary School Program:* The high school is operated in partnership with the Toronto District School Board and offers a broad range of grade 9 to grade 12 courses. Most Massey Centre students have had negative school experiences including: failures, suspensions, expulsions, and dropping out. This program is designed to meet the individual educational, social, and emotional needs of each student. Approximately 70 students enroll in the school each year.

*Success by Employment and Technology (SET) Project:* The SET project offers computer and job skills training for disadvantaged, high risk, young mothers who do not have the means to enroll and succeed in a mainstream business program. This is one of the few job training programs which offers free child care - a major barrier for disadvantaged mothers. This new program will serve over 60 clients this year. It is funded by HRDC.

*Compu-Lend Program:* Compu-Lend provides computers, on loan, to young mothers who are current clients. Young mothers can use their own computers to do homework assignments, instead of hand-writing them or going to labs in the evenings (difficult to do with young children).

*Health Care:* A staff nurse is available, on-site, for personal health counseling and to provide referrals for medical care. Prenatal classes, labour coaching, and workshops on infant care and development, are also offered. The nurse also assists the young women with family planning issues. In the postnatal phases, the nurse carefully monitors the development of the newborns.

*Community Program:* Our Community Program offers follow-up and community services to the vulnerable families leaving Massey Centre's residential programs and to high-risk families living in the community. Long-term housing and community stabilization are achieved through: employment counseling, violence prevention, life skills training, and community support. Families are monitored closely and referrals are made in a timely manner.

---

**Financial Information**

The total budget for the Centre is \$3.2 million. They fund raise for \$400,000 while the remainder is core funding from three levels of government – federal, provincial and local. The Ministry of Community and Social Services provide the provincial funding. The City of Toronto operates the day care centre. The core funding of \$3 million is automatic (federal, provincial and local). They seek funding from several foundations every year. The United Church pays the first mortgage on the Centre, and they hold the second mortgage as well. Over its years of operation, the United Church Women’s Groups, outreach committees and congregations throughout Ontario have contributed significantly.

Salary and benefits account for \$2.5 million of the \$3.2 million. They have 55 full time equivalent positions for staff. Regulations dictate how many staff is needed to run their programs.

**Massey Centre’s Study on Housing Stability/Instability**

The Massey Centre conducted a study intended to collect preliminary data to guide further research into the housing issues faced by former clients of the Massey Centre in terms of an affordable housing crisis (10). The effects of time and the corresponding differences in political, economic, and societal contexts on housing stability was examined by dividing former clients into two groups, those who left recently (within the last 2.5 years) and those who left some time ago (at least 4 years).

*Long Term Potential.* Seventy nine percent of recent clients compared to 25% of older former clients considered themselves to be at risk in terms of the long-term potential of their present housing. Clients who did not perceive their housing to have long-term potential lived in a shelter or doubled up with friends and family. As well, those who experienced difficulties, financial (affordability) and or personal (needing to hide from an abusive boy friend) also did not feel their housing to be long-term. Those who were able to afford their rent either because they lived in subsidized housing or because their income was sufficient to pay market value rent, felt that their housing had long-term potential.

*Housing Affordability.* Seventy-two percent of recent former clients paid market value rent compared to 44% of older former clients. Twelve percent of recent former clients and 38% of older former clients pay subsidized rents. The balance did not pay rent (live in a shelter, doubled up or living with their parent/s). If the standard is used that in Canada an income-to-rent ratio of greater than 30% constitutes housing affordability risk (11), the majority of recent former clients (72%) had affordability problems. However, the majority of older former clients (69%) have

housing that is affordable. Recent clients who rent market value units were found to pay between 27%-78% of household income for rent compared to older former clients who paid 23-69%.

*Move Frequency.* Older former clients moved less frequently than recent former clients since discharge.

*Educational Achievement.* There was a consistent trend between educational achievement and the client's mean long-term potential of housing rating. The higher the level of education achieved, the higher the mean long-term potential rating. There was not clearly discernable trend between mean income-to-rent ratios and educational achievement, but the higher the educational achievement, the low the mean move frequency.

*Stable Cohabitation with a Significant Other.* The mean long-term potential ratings for clients who are cohabitating and in a stable long-term relationship were higher than for clients who were single mothers. Likewise, clients living with their significant others also had lower mean income-to-rent ratios and lower mean move frequencies than single mothers.

## **Canadian Example of Drop-in Program for Pregnant and Parenting Teenagers**

**Jessie's Centre for Teenagers (Toronto, ON) (<http://www.jessiescentre.org/>)**

### **Background**

Jessie's Centre for Teenagers is a multi-service resource for pregnant and parenting teenagers aged 18 years and younger and their children. Jessie's is funded by the provincial Ministry of Community and Social Services. Jessie's mission is to nurture the healthy development of pregnant teenagers, teenage parents and their children. The Centre has developed programs and services to meet the special needs of this target group throughout the City of Toronto.

Jessie's opened its doors in January 1982 with four paid staff and volunteers. The Centre now has a staff of 13.5, augmented by a full-time teacher seconded from the Toronto District School Board, a Public Health Nurse from the Toronto Department of Public Health and 55 active volunteers.

Jessie's is located in downtown Toronto between two of Toronto's largest public housing projects – Regent Park and Moss Park. Although many teenage parents live in the area and use Jessie's Centre, a greater number travel from all over the city to attend programs.

Jessie's Centre occupies the first two floors of a six-story building owned by Jessie's. The remaining four floors accommodate 16 two and three bedroom apartments, which house a

mixture of teen families and older parents. This housing is intended to be permanent and all units are subsidized according to the tenant's income. The day-to-day operation is handled by a non-profit housing organization that practices a philosophy of tenant involvement in the management of the housing.

Jessie's was one of the first social service agencies in Ontario to pursue housing coops and other non-profits housing for subsidized housing for young families.

### **Profile of the Women Who Use Jessie's**

The women who come to Jessie's are between the ages of 13 and 19, with an average age of 17.1 years. In many cases, they receive social assistance. Some live on their own while others live with their family or with a partner. They most often live in families with incomes well below the Canadian poverty level. They average a grade 10 education and feel stigmatized because of their pregnancy. Some withdraw from school and peer relationships. Poverty affects every part of their lives, particularly their access to appropriate housing.

Unless subsidized housing has been acquired, most teen families spend 75 per cent of their income on rent. Housing is consistently inadequate for both parents and children. Often it is impermanent and many families are forced because of low income and lack of access to use women's or family shelters as temporary housing. Because such a large portion of their income is needed for shelter, their meager remaining money is quickly used on food, clothing, baby equipment, transportation, laundry and other essentials. These serious financial pressures create obstacles to long-term planning, and transient housing makes it difficult for adolescents to stabilize plans for themselves and their children.

Approximately, one-third of teen parents have histories of physical or sexual abuse; of these 44% have been abused, either during pregnancy or subsequently, by their current partner. In addition, one-third of these young mothers are at increased risk of poor physical health due to poor living habits. Smoking, drinking and drug use are risk factors often identified by the teens during intake.

Family support is an important factor for successful parenting by these adolescent mothers. However, for many adolescent, family contact is minimal or non-existent. Often the adolescent's own family is struggling with poverty issues and therefore, while their intentions may be positive, actual assistance is often limited or non-existent.

Many of these young parents have had a history of institutional and agency involvement before their pregnancy. They often view agencies, teachers and social workers as intrusive and insensitive.

**Services**

Jessie's provides a wide variety of services, and the women choose the ones which they feel best serve their own needs and those of their child. These services include:

- Nursery Drop In – A nursery which functions as a parent-child centre where opportunities for modeling, peer teaching and mutual support between teen parents occur, along with a much needed break from solely caring for their child can be had.
- Counseling – Each woman has a counselor who is available to her for personal counseling, information and advocacy.
- Health Care – There is a nurse available to address health questions and concerns of the pregnant and parenting teen mothers. Jessie's offers prenatal classes, breastfeed support, birth control information and a weekly Well Baby Clinic.
- Our School – On site secondary school program where high school credits can be earned.
- Parenting Education
- Housing Support – The Housing Counselor works with a team of trained and supervised volunteers to provide practical and concrete housing support to teen parents and their children.
- Prenatal Classes – Weekly evening prenatal classes are available for pregnant women and their partners or whomever they plan to have with them during labour and delivery.
- Labour Support Program
- Prenatal Nutrition Program (Food for Two) – Weekly prenatal care group which focuses on health and nutrition during pregnancy.
- Father's Group
- Parent Relief – Parents can arrange for a break by leaving their child in the care of the nursery to attend to some of their business or just to take some time for themselves.
- Practical Supports – Breakfast and lunch available each day that the Centre is open and dinner twice a week. When a young parent leaves Jessie's, they receive two Toronto Transit tickets – one to get home and one to get back. Baby clothes, toys, books, and emergency supplies of diapers and formula are examples of what is available in the Swap Shop and the Centre.
- Support Group for Breastfeeding Mothers
- Well Baby Clinic – weekly with the staff nurse and once a month with a doctor from the Hospital for Sick Children.

**Maritime Example of a Residential Home****Adsum for Women and Children (Halifax, NS) (<http://www.adsumforwomen.org/>)****Background**

Adsum for Women and Children is a charitable, community-based organization located in Halifax that supports women and children who are homeless or at risk of becoming so. Since its beginning in 1983, when it first opened as an emergency shelter, it has provided shelter and support services to more than 10,000 women and children. It was founded by the Sisters of Charity, Sisters of the Good Shepherd, Christ Anglican Church, Grace United Church and St. Peter's Roman Catholic Parish. Adsum operates three facilities: Adsum House (1983), an emergency shelter; Adsum Court (1987), a fifteen-unit apartment building; and Adsum Centre (2004), a residential home for women and their children.

Adsum Centre is located at Lakeside. The Centre supports up to sixteen women and children for a period of six to twelve months. All three levels of government made a commitment to this project. Residents of the Centre are selected through an admissions interview process. This is not meant to exclude people, but to ensure that the program and communal living guidelines are a fit to the individual's goals and lifestyle.

The women who take part in the Adsum Centre's programming must make a real commitment to meaningful change in their lives. The on-site programming is as customized to provide effective assistance as is possible to provide effective assistance to women who have had difficulty making the transition to independent living. Women living at the Centre take part in life skills programming, parenting skills, and can increase their employment skills.

**United States Examples of Residential Homes****St. Ann's Infant and Maternity Home (<http://www.saint-anns.com/>)**

St. Ann's Infant and Maternity Home has provided a refuge for needy women and children in the Washington, DC area since 1860 when three Daughters of Charity, a religious community dedicated to helping those who are poor established the city's first home for foundlings and single pregnant women. St. Ann's was chartered by President Abraham Lincoln on March 3, 1863. This is considered to be the first Second Chance Home in the United States. Throughout the years, the Home has served as an orphanage, an adoption agency, an emergency shelter for abused children, a training ground for teenage mothers and an affordable day care program for working families.

One of the current programs is the Teen Mother-Baby Program which provides residential care for 21 pregnant adolescents and young mothers and their babies. Extensive services include an accredited high school (50 girls attended classes last year), medical care, parenting classes, life skills training, day care, individual and family counseling, and social and cultural activities. Annually the program serves over 100 young mothers and infants.

## **Second Chance Homes**

### **Background**

Under President Bill Clinton's Administration, bold steps were taken to promote responsibility and prevent teen pregnancy by taking executive action to require young mothers to stay in school or risk losing welfare payments, enacting welfare reform in 1996, strengthening child support enforcement and launching a National Campaign to Prevent Teen Pregnancy (1). To build on this progress and to reach out to teen mothers, Clinton in his fiscal year 2001 budget included a provision to invest \$25 million in the creation and expansion of "Second Chance Homes".

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform mentioned previously) required most teen mothers under the age of 18 to live under adult supervision as a condition for receiving welfare. Recognizing that not all teen mothers had supportive families, the law specified that Second Chance Homes could provide an alternative. The law defined the homes as providing teen parents with supportive and safe living arrangements where they would be required "...to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote their long-term economic independence and the well-being of their children." Since 1996, States and communities have used federal Temporary Assistance to Needy Families (TANF) funds or state funds to create more homes of these vulnerable young families.

### **What Are They?**

Second Chance Homes are adult-supervised, supportive group homes, network of homes or apartment clusters for teen mothers and their children who cannot live at home because of abuse, neglect or other extenuating circumstances (2, 3). They can also offer supports to help young families become self-sufficient and reduce the risk of repeat pregnancies. They provide a home where teen mothers can live, but they also offer program services to help put young mothers and their children on the path to a better future.

Second Chance Homes programs vary across the country, but generally include:

- An adult-supervised, supportive living arrangement
- Pregnancy prevention services or referrals
- A requirement to finish high school or obtain a GED
- Access to support services such as child care, health care, transportation, and counseling
- Parenting and life skills classes
- Education, job training and employment services
- Community involvement
- Individual case management and mentoring
- Culturally sensitive services
- Services to ensure a smooth transition to independent living

**Where Are They?**

Nationwide, at least 6 states have made a statewide commitment to Second Chance Home programs: Massachusetts, Nevada, New Mexico, Rhode Island, Texas and Georgia (2). In these statewide networks, community-based organizations operate the homes under contracts to the states and deliver the services. States share in the cost of the program; refer teens to homes; and set standards and guidelines for services to teen families. In addition, there are many local Second Chance Home programs operating in an estimated 25 additional states. The Second Chance Homes National Directory, published by the Social Policy and Action Network in October 2000 listed one hundred homes in 29 states (3).

Among the existing statewide networks, there is a tremendous variation in how the programs are run and how they are funded. Massachusetts, for instance, operates its statewide network through two state agencies: the Department of Social Services and the Department of Transitional Assistance. As of October, 2000, there were 21 programs across the state – some of which are group homes or supervised shared apartments. Each program is different in structure and approach, but all of the programs offer stable housing and supports to young mothers and their children who do not have a place to live. Some programs maintain emergency beds for teens who have an immediate need for housing and who have no alternative place to live during the assessment period (4).

In New Mexico, there were 9 Second Chance Homes across the state in 2000. Unlike Massachusetts, the state has limited oversight of the programs. Instead, the state officials offer local communities start-up money and provide guidance on how to put together the programs and structure. They serve a wide range of backgrounds (including juvenile justice and foster care).

---

**Challenges to Service Delivery**

*Differing Levels of Need.* Part of the appeal of Second Chance Homes is the opportunity to offer tailored services to the individual having the direct knowledge of the services needed. For example, the primary needs of some teens may be a stable living environment, education or employment while others may have needs related to histories of physical and sexual abuse, domestic violence, and long-term poverty. The experiences from Massachusetts suggest that it is best to offer a range of services along with the ability to tailor services to each individual (5). Given that there is a variation in service needs of teenage mothers, programs have to be flexible and comprehensive or there will be both unmet needs and misused resources. It may be more harmful than beneficial to assume that all young mothers need the same core set of services (4).

*Need for Structured Environment.* Many programs already in existence are quite structured and restrictive. This has stemmed from the belief among program operators that in order to really help young mothers and enforce behavioural change, they need lots of structure and opportunities to learn all of the skills that are intended to help them improve their parenting and be able to provide for their children (6). Often this approach means that nearly every hour is accounted for with participation in some form of activity, leaving little or no free time. This results in some mothers being reluctant to stay and forfeit some of their freedoms.

Evidence from Massachusetts has indicated that some mothers dropped out due to the severity of the rules and regulations. Some mothers chose not to remain for other reasons: they missed their families; they succumbed to pressure from their boyfriends; or some had persistent drug or alcohol problems that were in violation of house rules, which meant that they could not remain in residence and had to seek treatment (if they chose to) somewhere else (4).

Some homes have been successful with a service model that begins with a highly structured environment, but offers teens more autonomy and flexibility as they progress through the program. For instance, in Rhode Island Second Chance Homes, teens begin by living in a highly structured group home with 24-hour supervision. As they make progress in school and improve their parenting skills, they move into a shared apartment situation with 16-hour supervision. In the last stage of the program, as they prepare for independent living, they move into individual apartments and a case manager provides guidance and supervision for eight hours each day (7).

*Coordination of Services.* Many Second Chance Homes are intended to be comprehensive in nature, requiring interactions with many different types of agencies. Deciding which agency has overall responsibility for coordinating services for participating teen parents must be done up front, as this influences the overall program orientation and functioning (3).

*Quality of Service May Be Contingent Upon Program Staff.* Service delivery and overall program success is contingent upon the individuals who are running the program and delivering services. A tremendous amount of patience and commitment is required of the program staff when dealing with many of the issues that are facing resident teens and their young children. Recruitment, training and retention of staff are issues that need very careful consideration (3).

*Need For Community Support.* Many of the characteristics of a model Second Chance Home (committed staff, comprehensive services, highly structure environment) suggest that the program design and service delivery must be highly responsive to the needs of the community where the home is located, and specifically the young women who are in need (3). The infrastructure and public support for these homes need to be in place in order for a program to be sustained.

### **Elements of a Successful Home: A Social Contract**

Successful prototypes for group homes respond to the reality of teen mothers' lives, and their design incorporates all the three elements necessary to offer them a chance to succeed:

- Socialization,
- Nurturing and support, and
- Structure and discipline (8).

Sylvester<sup>11</sup> gave brief descriptions of 14 model Second Chance Homes which exist in a number of states. These residential facilities are small or large; usually funded by varying combinations of private and public monies; and are located in inner cities and rural area (8). In her briefing, she outlined why these are successful prototypes for residential group homes which respond to the reality of teen mothers' lives, and their design incorporates all the three elements mentioned above.

### **Evidence of Effectiveness**

There is very limited rigorous evaluative information on the effectiveness of Second Chance Homes. One study was conducted in Massachusetts which had a statewide program in 1998 (9). The authors described the key issues related to the implementation of this program and the delivery of the services to the teen parents based on 21 of the 22 sites where homes were located.

---

<sup>11</sup> [http://www.ppionline.org/ppi\\_ci.cfm?knlgAreaID=115&subsecID=900025&contentID=2063](http://www.ppionline.org/ppi_ci.cfm?knlgAreaID=115&subsecID=900025&contentID=2063)

They found the following with respect to some of the critical program components:

- *Education.* All sites offered a variety of educational options including access to public high schools, technical or vocational training programs, GED programs, and community college systems. Although a variety of programs were available, the GED programs were utilized most often. This related to the teen mother's discomfort in returning to school when they were not at an age-appropriate grade level. Some school systems are biased against teen mothers.
- *Employment services.* Employment was not encouraged while in the program because of the educational and other program requirements and part-time work in addition to school attendance would interfere with the parent-child interaction time that was critical to client success. Employment-related issues such as appropriate dress, job application and resume writing, and interviewing techniques were addressed through life skills instruction.
- *Child Care.* Three sites had on-site child care and 18 used community child care. In terms of their role in accessing appropriate child care, sites checked out existing child care options, provided support to the mothers in selection of appropriate child care, and facilitated transportation to child care.
- *Health services.* All sites had access to health care services for the teen parents and children. Some reported excellent relationships with local providers, particularly if they had specialized services for teen mothers. Others had relationships with a visiting nurses program, or another community-based health care service, which provided preventive and educational services at the program site. Some health care providers are biased against teen mothers.
- *Life skills training and parenting skills training.* The Department of Social Service's curriculum for independent living skills was utilized at all sites. Consistently, this curriculum provided good and useful material except for higher skilled clients where it was too basic. There was requirement to supplement and to provide individualized activities to meet individual needs.
- *Housing search assistance.* All sites discussed substantial limitations in providing housing search assistance and the much needed linkage to appropriate, safe, and moderately priced housing that is required when teen mothers exit the program.
- *Follow-up services.* Programs attempted to maintain contact with former clients but generally expressed having a hard time consistently following up the young women who left the program due to limited staff time. This was seen to be a particular problem because of a newly implemented Department of Social Service's standard which states that follow-up services are to be provided every 6 months for up to 2 years.

The need for evaluation is being recognized as a key component in new program design for residential homes (3). It has been suggested that any new program build evaluation activities, such as tracking outcomes of participants, into the everyday operations. In addition to informing program operators and funding agency/agencies of the overall success of the program in achieving the intended outcomes, evidence from this kind of process evaluation can be useful in informing others who are interested in starting or redesigning a Second Chance Home about policy issues and operational lessons (7).

## **Maternity Residential Homes**

### **Program Components and Service Delivery**

*Housing Structure.* The most fundamental need filled by maternity residential homes is housing (12). Two basic housing structures are used by maternity residential homes - congregate and clustered apartments. The majority of the Second Chance Homes in the United States used congregate structures, while about 25% used clustered apartments and 8% used a combination of the two types<sup>12</sup>. Congregate homes are often in buildings which were formerly large single-family houses. In these homes, some residents share a bedroom with another teen, while in some of the large homes; each teen has their own bedroom. Kitchens and living areas are shared, and bathrooms may be private or shared. Clustered apartment structures may fill and entire building with teen families, or they may only have a few units in a larger apartment building. Some networks vary their housing structure deliberately to offer residents a continuum of housing types such that the teen families can move in stages toward independent living. Rhode Island has three different levels: young teens begin their program in congregate homes and then work their way through two stages of transitional apartments as they become more self sufficient (6).

*House Rules.* Maternity residential homes usually impose numerous restriction and obligations on residents, both to provide needed structure for the teen mothers living there and to teach them responsibility and skills they will need to be self-sufficient once they leave the home (12). Residents of congregate homes typically share responsibility for preparing group meals and cleaning common areas in the home. Teens living in clustered apartments are responsible for preparing meals for themselves and their children and are required to keep their own apartment clean.

*Limits on Length of Stay.* Although Residential Maternity Homes allow families to remain in residence for as long as they meet the program eligibility requirements (which includes maximum age), others have set limits on the length of time a teen can live in the home regardless of their

---

<sup>12</sup> Social Policy Action Network. (2001). Second Chance Homes National Directory. Washington, DC: SPAN, November.

age (12). More than 33% of Residential Maternity Homes which responded to the 2001 SPAN survey reported time limits. The most common limit reported was also the longest reported by any respondent: two years. Teens do not necessarily remain for the maximum amount of time these limits allow as they may age out before reaching the limit; they may find an alternative housing situation; or become dissatisfied with the program.

*Supervision.* A basic component shared by all Residential Maternity Homes is adult supervision. Adults provide informal counseling, emotional support, and nurturing to resident teenage women, as well as enforce program rules and offer other support services. Staffing patterns vary widely across Residential Maternity Homes, depending on funding, intensity of supervision, and amount of support services provided. Homes responding to the 2001 SPAN survey reported more full-time equivalent staff than teen families. The mean staff-to-teen mother ratio was about one-to-one.

Because teen parents have high needs for support and supervision, most homes are staffed 24 hours a day (12). In Rhode Island homes, the number of hours during which staff are on site decreases at each of the three stages, from 24 hours to 16 to 8, as the teens move toward independent living.

The types of staff employed vary from home to home – full-time paid staff, part-time paid staff, volunteers. The credentials and roles staff play also vary.

*Support Services Provided.* Besides the basics of housing and supervision, pregnant and parenting teens have a wide variety of needs ranging from immediate medical and mental health to education and job-training services. Reliable child care and transportation are necessary to ensure the mothers make use of other services. The homes can either offer support services themselves or refer their residents to outside providers (12).

Almost all maternity group homes offer a set of basic services – life skills and parenting classes and assistance connecting with outside services as well as commonly providing supports to enable teens to avail themselves of outside services. About 75% of the homes responding to the SPAN survey provided transportation for residents to get to school and/or child care. Just fewer than 50% had child care themselves and many had relationships with off-site child care providers to care for children while parents were attending school, training, or work.

It is not uncommon for homes to provide such services as education, GED preparation or job training on site (12). Nearly 60% of those responding to the 2001 SPAN survey reported providing job training and counseling while 15% provided high school and/or GED education. Many provide medical, mental health, substance abuse treatment, family planning, abstinence

education, and pregnancy prevention services. About 50% provided mental health services and about 20% offered medical services. Some provide mentors, services for fathers, outreach to families, and follow up for former residents.

### **Population served by Residential Maternity Homes**

*Capacity.* The maximum number of residents that a home can house at any one time is dependent on the managing organization based on their program goals, funding and the housing facilities available (12). The number of families living in a facility contributes to the home environment and thus potentially affects program outcomes. There was some evidence from a study of Massachusetts' network that home size may be negatively correlated with satisfaction (4). On the other hand, larger facilities may benefit from economies of scale.

A majority of homes are quite small. Some homes serve as few as two teen families at a time, while others may serve as many as 47<sup>13</sup>. Just over 50% surveyed by SPAN in 2001 reported capacities below 10 families, and only 11 homes have facilities with more than 20 families. The mean was about 11 families.

*Target Population.* Pregnant and parenting teens are not a homogenous population.

- *Age:* Most homes serve a limited age range. Some focus on younger teens (e.g., age 12-18), while others target older teens and even young mothers in their early 20's (e.g. up to 21 or 17-25). Some homes have no age limits at all while others are flexible about their official limits.
- *Family Composition:* Homes usually place limits on the family composition of residents. Many homes serve both pregnant and parenting teens, but some serve teen families only after a baby is born, and a few serve only pregnant teens, which must move out shortly after giving birth. Most only serve single parents, primarily mothers, but some allow single fathers, and at least one was specifically designed to serve two-parent families (7).

### **Literature**

1. Clinton, B. (2000). Memorandum for the Secretary of Health and Human Services, the Secretary of Housing and Urban Development. August 11, 2000. ([http://findarticles.com/p/articles/mi\\_mw889/is\\_33\\_36/ai\\_65806224](http://findarticles.com/p/articles/mi_mw889/is_33_36/ai_65806224))
2. US Department of Housing and Urban Development. (2001). Second Chance Homes. Washington, DC: US Department of Housing and Urban Development. (<http://www.hud.gov/offices/pih/other/sch/index.cfm>)

---

<sup>13</sup> Ibid.

3. US Department of Health and Human Resources. (2000). *Second Chance Homes: Providing services for teenage parents and their children*. Washington, DC: US Department of Health and Human Resources, Office of the Assistant Secretary for Planning and Evaluation. (<http://aspe.hhs.gov/hsp/2ndchancehomes/>)
4. Collins, M., Lane, T., and Stevens, J. (2000). *Teen Living Programs: An analysis of implementation and issues in service delivery*. Boston University School of Social Work: Boston, MA. Prepared for the Massachusetts Department of Transitional Assistance.
5. Collins, M. (1998). *Evaluation of Programs for Teen Parents and Their Children*. Boston University School of Social Work: Boston, MA. Prepared for the Massachusetts Department of Transitional Assistance.
6. Sylvester, K. (1999). *Second Chance Homes and the TANF Minor Parent Living Arrangements*. Washington, DC: Social Policy Action Network.
7. Reich, K. and Kelly, L. (2000). *A place to call home: Second Chance Homes in Georgia*. Washington, DC: Social Policy Action Network.
8. Sylvester, K. (1995). *Second-Chance Homes: Breaking the Cycle of Teen Pregnancy*. Washington, DC: Progressive Policy Institute. Briefing, June 23.
9. Collins, M. E., Lane, T. S. and Stevens, J. W. (2003). Teen living programs for young mothers receiving welfare: An analysis of implementation and issues in service delivery. *Families in Society: Journal of Contemporary Human Services*, 84(1), 31-38.
10. Fara-On, M. (2002). An investigation of the factors that contribute to the housing stability/instability of former clients of Massey Centre. (<http://www.massey.ca/newpage12.htm>)
11. Pomeroy, S. (2001). *Toward a comprehensive affordable housing strategy for Canada*. Caledon Institute of Social Policy. October.
12. Hulsey, L. (2004). *Maternity group homes: Classification and literature review*. Final report submitted to Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Washington, DC: Mathematica Policy Research, Inc. (<http://aspe.hhs.gov/hsp/grouphomes04/litreview04/report.pdf>)

**Topic V. Societal and financial costs of “doing nothing”/or conversely, providing support****Introduction**

The costs of “doing nothing” particularly the more economic ones are very difficult to calculate precisely and as such this literature review uses primarily studies which have looked at societal costs. Since poverty is so prevalent among single parent families and particularly those headed by a teen mother, the cost of poverty and measures of change are very important. One of the difficulties with measuring the cost of poverty, as well as matters related to human well-being and quality of life, is that economic and social policy have historically developed on different tracks, without recognizing how interdependent they are (1). Basically, economic policy has concerned itself with money and social policy with people.

The National Council of Welfare (1) stated that no one has attempted to put a global dollar figure on how much poverty costs, and it was certainly beyond the Council's capacity to do so. They said that there is ample evidence that poverty not only results in personal human misery, but it does not make good economic sense.

**How Does Poverty Cost Canadians?**

The following are a few ways in which poverty costs taxpayers. All of these are pertinent to single-mother families particularly to teenage mothers.

*Health.* The health field provides a key example of how reducing and preventing poverty in the first place is more cost-effective than paying for its consequences. Population health evidence points to the increased costs to the health care system, and the decreases in the academic achievements, health and life spans, of those populations at the bottom end of the socio-economic scale.

The health problems of poor children begin before birth and place these children at greater risk of death, disability and other health and developmental problems throughout infancy, childhood and adolescence. At birth, children from the poorest neighbourhoods in Canada have a life expectancy between 2 and 5.5 years shorter than of children from the other end of the economic scale (1). Children from the poorest neighborhoods can also expect to spend more of their lives with disabilities and other health problems. The rate of childhood disability was over twice as high for children from poor families than for children from rich families (2).

---

Findings from Canada’s National Longitudinal Survey of Children and Youth found similar evidence. Again and again, the Children’s Survey found that children at the lower end of the socio-economic scale had poorer health and developmental outcomes than children in the middle and significantly more for children at the top of the scale (1).

Parents at the lower end of the scale showed the effects of living in poverty. They suffered increased stress and poorer functioning with their children and higher levels of depression, which are bound to have serious effects on the capacity of parents to take the best care of their children (3, 4).

*Justice.* Grogger (5) looked at the higher involvement in crime by male children of adolescent mothers. He estimated that the sons of adolescent mothers are 2.7 times more likely to be incarcerated than the sons of mothers who delay childbearing until their early 20’s. In the United States, about 5 percent of all young men were found behind bars over a 13-year period. This is well below the 10.3 percent rate of observed incarceration for young men born to adolescent mothers and slightly above the 3.8 percent for young men born to mothers who began their families at age 20 or 21.

Roughly half of the observed difference for young men born to adolescent versus older mothers is accounted for by observable differences in the demographic and background characteristics of offspring of both groups of mothers. Using computer simulations, Grogger (5) estimated that if these adolescents postponed childbearing until age 20 or 21, it would, by itself, reduce the incarceration rate for the affected children by 13 percent (from 10.3 to 9.1 percent).

Even the relatively small fraction of the higher incarceration rate that is directly attributable to adolescent childbearing is extremely costly to society. In the United States, Grogger (5) stated that a delay in childbearing until the age of 20.5 would reduce the U. S. average incarceration rate by 3.5 percent, for an annual savings of about \$1 billion in correctional costs and a potential savings of nearly \$3 billion in total law enforcement costs. What is even more important is that these results are long range. Even if all prospective adolescent mothers were to delay their childbearing immediately, the incarceration rates would not fall as predicted by Grogger’s estimates for about 20 years – the earliest age at which young offenders start going to jail in any substantial numbers.

*Child Protection.* Goerge and Lee (6) addressed the association between adolescent childbearing and the incidence of child abuse and neglect. In their study of children in Illinois, children born to adolescent mothers were found to be twice as likely to be victims of abuse and

---

neglect as children born to 20- or 21-year-old mothers. These differences were not narrowed by statistical controls for the background factors such as region of the State or birth cohort that could be controlled for in their analysis.

The ratio of foster-care placements to reported abuse and neglect was roughly one in four among children born to adolescent mothers and one in five among children born to older mothers. Abuse and neglect rates and foster care rates continue to decline with longer delays until women give birth. For example, delaying childbearing from under age 16 until age 20 or later leads to a 30-40 percent greater impact on the incidence of reported abuse and neglect than does a delay from age 17 to age 20 or later. If their results are generalized to the United States, the results of this study would imply that as many as 5 percent of foster care placements could be averted if adolescent childbearing were eliminated.

As can be expected given their results, Goerge and Lee's computer simulations of the costs of abuse/neglect and foster care placement indicated that the costs to society would be substantially reduced if childbearing could be delayed. If women at the time of the study bearing children at age 17 or younger delayed childbearing until at least ages 20 or 21, the annual savings in foster care nationwide (U.S.) could reach about \$1 billion. A similar delay could reduce the costs of abuse/neglect investigation by almost \$100 million a year. The causal chain leading to incidents of abuse and neglect and to foster care placements is as yet unclear, however. These simulations assumed that a policy that leads to childbirth delays would also ameliorate whatever it is that leads to child abuse/neglect and foster care placement.

### **Various Studies**

A study of the long-term economic outcome for a sample of Canadian women who married and/or had children before the age of 20 was carried out by Grindstaff (7). He used the information from the 1981 census to examine the economic situation of women who were 30 when the census was taken. Using a sample of approximately 200,000 women, he subdivided the group into subgroups based on age at first birth, age at marriage, and single or childless status. His findings showed that the earlier the age at marriage and age at first birth, even for those women over 20, there was low educational achievement of the women. By the age of 30, 58% of women who were married and had children as teens were in the paid labour force, with 68% of these having full-time employment. For those women who married and had children after 25, the corresponding percentages were 54% employed and 65% full-time. These statistics reflect the long-term labour market participation of teen mothers rather than the short-term picture that generally is one of increased unemployment and limited employment. Grindstaff (7) speculated

---

that the larger market participation of teenage mothers was based on a greater economic need for income by these women.

Both marriage and childbearing at an early age tend to limit a woman's job opportunities to mostly nonprofessional occupations. Grindstaff's study suggested that it was age at marriage and childbearing at any age that was more closely associated with employment prospects, independent of age of first birth.

A long-term study of Nova Scotia mothers and their children was conducted by the Nova Scotia Department of Community Services (8, 9) presented the findings on the socioeconomic outcomes related to teen pregnancy and single parenthood vs. married parenthood. They followed a sample of women of varying ages who had their first child during the last six months of 1978 and the first two months of 1979. The data were analyzed according to age at birth and marital status. Initially, there were 403 unmarried women and 416 married women in the study. The sample was broken down into two age groups, those 19 years and younger and 20 years and older. After the birth of the child, each mother was interviewed at intervals of 7 weeks, 9 months, 18 months and 10 years. At the 10-year interview, 84% (349) of the married individuals from the initial group participated as did 62% (250) of the unmarried individuals. Interviews sought to measure the participants' self-perceived satisfaction with 12 dimensions of life including health, finances, family relations, employment, friendships, education, self-esteem, marital situation, religion, recreational activities and transportation. At 10 years, the children were tested psychologically and educationally.

Unmarried mothers of all ages reported most dissatisfaction with educational achievement. The data revealed that those women who were in school when they became pregnant were more likely to return to school after giving birth than those who dropped out prior to their pregnancy. The older unmarried mothers were less likely to complete their education than were the younger unmarried mothers since they were also more likely to have dropped out of school before becoming pregnant. Young unmarried mothers (87.3%) were more likely to marry over the 10-year period than were their older unmarried counterparts (69.4%). The unmarried mothers in general waited longer to have their second child than did the married mothers of all ages. Unmarried mothers had slightly less children (2.01) than did married mothers (2.31). Over the 10-year period, only 3% of all mothers received social assistance for 9 or more years. However, 32.8% of all mothers lived in poverty, a rate twice the provincial rate. Older, married mothers who had higher levels of completed education were more likely to have professional positions with greater salaries. Lower levels of education and work-related experience limited the employment opportunities of younger mothers (8).

---

For almost all the areas of life satisfaction examined in this Nova Scotia study, older married mothers tended to fare the best. However, because there was a diversity of responses within each group, it could be concluded that these are not homogeneous populations. While the younger unmarried mothers began parenting with more socio-economic handicaps, they made the most gains over 10 years although they lagged behind the married group in terms of self-reported satisfaction and measurable gains. With respect to the young unmarried mothers, the authors note that their disadvantaged position vis-à-vis the older married women is not merely a function of age. The older unmarried mothers also experienced more difficult circumstances than their married counterparts, and in some instances, appeared more disadvantaged than the young unmarried mothers (8).

The financial cost of adolescent pregnancy include those directly related to pre- and postnatal care, abortion services and the social support very often required (9). In 1993, there were approximately 2,700 families headed by teenage mothers (or those who were teenagers when they first became mothers) receiving family benefits in Nova Scotia (10). It has been estimated that each dollar spent on the prevention of adolescent pregnancy would result in ten dollars saved (11).

While there have not been detailed Canadian studies of patterns of welfare use by teenage mothers (12), Canadian welfare statistics offer some insight into welfare trends based on age, fertility and marital status (13). According to 1997 figures, teenage single parents accounted for 3% of all single parents on welfare. Few (4%) heads of families of welfare cases were under the age of 20, and 12% were between the ages of 20 and 25.

The literature (12) demonstrates that there are definite negative consequences associated with teen pregnancy. When compared to women who delay their childbearing past the teen years, women who become teen mothers are less likely to complete high-school, more likely to work at low-income jobs and experience longer periods of unemployment, more likely to receive welfare benefits during the years following birth and more likely to experience single parenthood and higher levels of poverty. The fact that a large percentage of teen mothers come from socio-economically disadvantaged backgrounds means that they suffer many of the negative consequences of teen pregnancy by virtue of their family status and pre-pregnancy life situation.

Not only does teen childbearing have serious consequences for teen parents, their children and society; it also has important economic consequences. Helping young women avoid too-early pregnancy and child bearing is easier and much more cost effective than dealing with all the problems that occur after the babies are born (14).

---

Teen childbearing cost U.S. taxpayers at least \$7 billion a year or \$3200 a year for each teenage birth in direct costs associated with health care, foster care, criminal justice, and public assistance, as well as lost tax revenues based on a study by Rebecca Maynard of Mathematica Policy Research in Princetown, New Jersey (15). A cost benefit analysis suggested that the U. S. government could spend up to eight times more than it is currently spending on teen pregnancy prevention and still break even (16). Another study which estimated the cost-effectiveness and cost-benefit of one particular curriculum for preventing teen pregnancy found that for every dollar invested in the program, \$265 in total medical and social costs were saved. The savings were produced by preventing pregnancy and sexually transmitted diseases (17).

A project at McMaster University studied the effects of direct services on 765 single-mother families and 1,300 children who had been on welfare for four years (1). The study provided a variety of direct services that are commonly used by families in this situation:

- Subsidized daycare
- Recreation services for the children
- Public health nurses for the mothers
- Employment training for the mothers, or
- A combination of all four types of services.

The study then tracked the health status, health care and social services expenditures and welfare status of the families. Almost half (45%) of the mothers in the study had the signs and symptoms of major depression when the project began. Depressed parents also had higher annual expenditures for the use they and their children made of the public health care and social services.

After two years, the researchers found that the depression rates of the mothers dropped to only 20% from 45%. The social adjustment scores of mothers improved. Each of the services offered to the families resulted in an increase in the number no longer on welfare. It was estimated that the increase in parents no longer on welfare was worth \$300,000 a year for every 100 mothers. The savings from reduced use of the public health care system was an additional savings. Also, all the costs of providing the services to these families were completely offset by the reduction in the costs of parents' and children's use of the services of physicians, other professionals and the child protection system. Just providing child care and recreation services – even without the combination of other services – proved the most effective and the most cost-effective (18).

### **Medical Care Utilization**

Wolfe and Perozek (19) explored a wide range of measures of medical care utilization and compared the differences between the children of teen mothers and older mothers. These

---

measures included visits to doctors, clinics and emergency rooms, and hospital stays. Except for emergency room visits, of which there was greater use by the children of teen mothers, all indicators of utilization showed that the children of older mothers had higher utilization rates. This presumably could be explained by their finding that the children of older mothers had more acute and more chronic conditions than the children of teen mothers.

How did these utilization differences translate into sources of payment and costs of care? Children of older mothers had more of their care paid for directly by their families (47% versus 38%) and by private insurance (32% versus 16%). In sharp contrast, much more of the care of teen parents' children was paid for by public sources (49% versus 20%). Consistent with these findings, the costs of medical care were greater for the children of older mothers than for teen mothers, but the amount paid by other members of society was greater for the children of teen mothers.

### **Low Birth Weight Children**

As indicated earlier, teenage mothers are more likely to have low birth weight babies than older mothers. A study which examined the increased spending on health care, education and child care for children with low birth weight concluded that ten percent of all health care for children is spent on children with low birth weight (20). The components of the total cost for low birth weight includes the costs of medical care, special education, early intervention and other support services and these are disproportionately consumed by low birth weight children. In 1988 in the United States, health care, education, and child care for the 3.5-4 million children aged 0-15 born low birth weight cost between \$5.5 and \$6 billion more than they would have if these children had been born normal birth weight (20).

### **Adding Up the Costs**

This section is a summary of the final chapter of *Kids Having Kids* (21), much of which is reported above and elsewhere in this Literature Survey. In this chapter, an overall sense of the range of savings that could be achieved if public policy interventions were able to prevent young teens from having children until they were 20 or 21 (and presumably, public policy interventions put in place to change the circumstances of young teen mothers) are summarized. Prior to this book, the previous attempts to estimate the costs of early childbearing focused rather narrowly on public welfare costs. The range of outcomes examined in the *Kids Having Kids* studies allows a much broader perspective.

Deriving a more comprehensive set of cost estimates would be an extremely complex exercise. Because of data limitations and methodology differences used by the authors of the component studies, as well as a whole variety of assumptions that always have to be made in order to build a

---

comprehensive cost picture, there was no “best” answer to the cost question. Therefore, Maynard (21) provided “baseline” cost estimates that combine the impacts as estimated by the various authors contributing to *Kids Having Kids* with only a minimum set of assumptions necessary to fit them into a cost-accounting framework. She then provided an additional range of estimates that illustrate how the findings change as the assumptions underlying the separate analyses were altered.

For the baseline estimates as well as for the sensitivity analysis, two policy scenarios were used and the costs for each determined. The first, which yielded lower bound savings estimates, was that policy intervention succeeds in delaying childbearing until the mother is age 20 or 21, but made no other changes to the wider environment. The second, which yielded higher estimated savings, assumed that the policy that was successful in postponing the age of the first childbirth also addressed the maximum set of policy-influenced factors that led to poor outcomes (such as motivation, educational opportunities, and various social and economic support needs.)

*Baseline Estimates.* The lower bound estimates indicated that early childbearing cost U. S. taxpayers nearly \$7 billion annually for social services and lost tax revenues. The upper bound estimates indicated that taxpayers could save as much as \$15 billion annually; if there was success in preventing young teen childbearing and if many of the problems that contribute to the poor outcomes observed for teen parents were addressed. At the time that this book was written (1997), the record of interventions suggested that even strong policies may leave the U. S. closer to the lower bound estimates than the higher figure.

The costs to society are about twice those for social services and lost tax revenues, e.g., \$15 billion a year due to early childbearing alone, and up to \$30 billion a year if all the risk factors amenable to policy influence were successfully eliminated.

This study (21) indicated that the economic welfare of the teens would not be greatly affected by policies that prompted them only to delay childbearing. Policies that delayed their childbearing but changed nothing else would in fact leave the teens with about \$850 a year less income. If they simultaneously addressed the maximum set of related disadvantages that conceivably could be affected by the policy, the young women could find themselves with roughly \$ 1,000 more income annually during their early parenting years.

*The Basic Message.* The final cost chapter of *Kids Having Kids* provides a good summary of the book’s basic message. The economic costs for the mothers of early childbearing were small to nonexistent. Rather, the consequences for the mothers were not monetary and often not observable for several years following their first birth. Young teen mothers were much less likely to complete high school, spent more of their years of parenthood single, and had their children

---

over a somewhat shorter time period. During their children's elementary and middle school years, early child bearers also spent slightly more time out of the home and in the labour force than if they had delayed childbearing. In addition, they created less supportive home environments for their children. The most important message in the book was that young teen childbearing has significant adverse consequences for the children and these consequences cost taxpayers and society enough to merit close policy attention.

### **Assessing Teenage Pregnancy Prevention Programs**

In reviewing the teenage pregnancy literature, Dilworth (22) addressed the importance of prevention programs from an economic standpoint. She provides three estimates of the cost of teenage pregnancy from the standpoint of prevention.

- Planned Parenthood said that for every dollar spent on the prevention of teen pregnancy, ten dollars could be saved on the costs of abortions and the short and longer term costs of income maintenance to adolescent teenage mothers (23).
- An Ontario-based cost-benefit analysis showed that preventative programs between 1975 and 1983 helped to avoid over 21,000 adolescent pregnancies for a net savings of \$25 million (24).
- In 1986, Orton and Rosenblatt estimated that for every \$1 spent on family planning services, more than \$10 is saved in welfare and family benefits alone (25). Planned Parenthood Nova Scotia (11) estimated that for every \$1 spent on the prevention of unhealthy sexual outcomes, \$10 was saved in health and social assistance.

### **Literature**

1. National Council of Welfare. (2004). The cost of poverty (Winter 2001-02). Ottawa, ON: National Council of Welfare.  
[http://www.ncwcnbes.net/html/document/reportcostpoverty/Costpoverty\\_e.htm](http://www.ncwcnbes.net/html/document/reportcostpoverty/Costpoverty_e.htm)
2. Wilkins, R., and Sherman, G. J. (1998). Low incomes and child health in Canada *In Health and Canadian Society: Sociological Perspectives*, D. Coburn, G. M. Torrance and C. D'Arcy (Eds.), Toronto: University of Toronto Press.
3. Ross, D. P., Roberts, P. A. and Scott, K. (1998). Variations in child development outcomes among children living in lone-parent families. Ottawa: Applied Research Branch, Human Resources Development Canada. October.
4. Ross, D. P., Scott, K. and Kelly, M. A. (1996). Overview: Children in Canada in the 1990s. Ottawa: Applied Research Branch, Human Resources Development Canada. R-97-2E
5. Grogger, J. (1997). Incarceration-related costs of early childbearing *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*, R. A. Maynard (Ed.), Washington, DC: Urban Institute Press.

- 
6. Goerge, R. M. and Lee, B. J. (1997). Abuse and neglect of the children *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.
  7. Grindstaff, C. F. (1988). Adolescent marriage and childbearing: The long-term economic outcome, Canada in the 1980s. *Adolescence*, 23, 45-58.
  8. Nova Scotia Department of Community Services (NSDCS). (1991). Mothers and children: One decade later. Halifax, NS: NS Department of Community Services.
  9. Langille, D. (2000). Adolescent sexual health services and education: Options for Nova Scotia. Policy Discussion Series Paper No. 8, Halifax: Maritime Centre of Excellence for Women's Health.
  10. Planned Parenthood Nova Scotia. (1995). Towards sexual and reproductive health for Nova Scotians: A proposal to the Department of Health. Halifax: Planned Parenthood.
  11. Health Canada. (1998). A report from consultations on a framework for sexual and reproductive health. Ottawa: Health Canada.
  12. Bissell, M. (2000). Socio-economic outcomes of teen pregnancy and parenthood: A review of the literature. *Canadian Journal of Human Sexuality*, 9(3), 191-105.
  13. National Council of Welfare. (1998). Profiles of welfare: Myths and realities. Ottawa, ON: National Council of Welfare.
  14. National Campaign to Prevent Teen Pregnancy (NCPTP). (2002). Not just another single issue: Teen pregnancy prevention's link to other critical issues. <http://www.teenpregnancy.org>.
  15. National Campaign to Prevent Teen Pregnancy (NCPTP). (2001). Halfway there: A prescription for continued progress in preventing teen pregnancy. Washington, DC: National Campaign to Prevent Teen Pregnancy.
  16. Sawhill, I. V. (2001). What can be done to reduce teen pregnancy and out-of-wedlock births? Brookings Policy Brief 8.
  17. Kirby, D. (2001). Emerging answers: Research findings on programs to reduce teen pregnancy. Washington, DC: National Campaign to Prevent Teen Pregnancy.
  18. Browne G., Roulston J., Ewart B., Schuster M., Edward H. J., and Boily L. (2001). Investments in Comprehensive Programming: Services for Children and Single-Parent Mothers on Welfare Pay for Themselves within One Year. *In Our Children's Future: Child Care Policy in Canada*, Chapter 21, University of Toronto Press Inc.
  19. Wolfe, B., and Perozek, M. (1997). Teen children's health and health care use *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.
  20. Lewit, E. M., Baker, L. S., Corman, H. and Shiono, P. H. (1995). Direct cost of low birth weight. *The Future of Children*, 5(1).
  21. Maynard, R. A. (1997). The costs of adolescent childbearing *In Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. R. A. Maynard (Ed.). Washington, DC: Urban Institute Press.

---

22. Dilworth, K. (2000). Literature Review (Teenage Pregnancy). Canadian Institute of Child Health.  
([http://www.phac-aspc.gc.ca/dca-dea/publications/reduce\\_teen\\_pregnancy\\_section\\_2\\_e.html](http://www.phac-aspc.gc.ca/dca-dea/publications/reduce_teen_pregnancy_section_2_e.html)).

23. Planned Parenthood Federation of Canada. (1999). Planned Parenthood Donor Update. Spring.

24. Childbirth by Choice Trust. (2000). The economic \$ of contraception, abortion and unintended pregnancy. Pamphlet. Toronto: Childbirth by Choice Trust.

25. Orton, M. J. and Rosenblatt, E. (1986). Adolescent pregnancy in Ontario: Progress in prevention. Report No. 2, Planned Parenthood Ontario.