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ABSTRACT

In order to provide guidance for agencies in developing effective programs for pregnant and parenting teens, this article analyzes data from 21 federally funded care programs involved in a national evaluation. First, the question of a program's location and structure was addressed. Rural projects were found to be less service-rich than their urban counterparts and non-hospital programs of several varieties all delivered more services of most types and more total services than did hospital projects. It was concluded that the key to a good program lies more in competent management and good community relations than in specific structures or models. Second, with regard to client characteristics, girls who entered the programs pregnant were found to receive more services than those coming in as entry mothers, and girls on welfare received more services than those who were not. Third, an examination of service costs revealed that even more important than the absolute cost of different client types was the contrast between clients' entitlements and what they get "extra" in these programs. Fourth, an examination of project implementation and management uncovered the need for adequate lead time to develop interagency coordination; the need for adequate case management, client record keeping and tracking; and the need for greater emphasis on services to parenting teens. Finally, programs are urged to take seriously the needs not only of pregnant teens but also of teen parents and school dropouts. (RDN)

PLANNING ADOLESCENT PREGNANCY PROGRAMS: IMPLICATIONS OF A NATIONAL EVALUATION

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PLANNING ADOLESCENT PREGNANCY PROGRAMS: IMPLICATIONS OF A NATIONAL EVALUATION[1]

Introduction

In recent years, human services and welfare departments have become increasingly aware of the need to do something about adolescent pregnancy and parenting. A number of state human services agencies have already initiated demonstration projects, and other state agencies are contemplating similar action. A growing recognition that mothers who had their first baby as a teenager account for sizeable proportions of AFDC caseloads[2] has kindled some of this interest, along with known health risks to mother and infant of teenage childbearing and the increasing number of children born out-of-wedlock.

As always in a relatively new area of programming, agencies interested in developing effective programs for pregnant and parenting teens could use some guidance in deciding what types of programs to support, in what agencies, for which clients, with what types of service and service structure, for how long, and at what cost. To shed light on these issues, this article uses data from 21 federally funded care programs for pregnant and parenting teens that were part of a national evaluation. (Very few of these programs had a primary prevention component, and even where this was present, the evaluation focused exclusively on care services for teens who were already

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[1]This article is based in part on Burt, Martha R., Kimmich, Madeleine L., Goldmuntz, Jane and Sonenstein, Freya L. Helping Pregnant Adolescents: Outcomes and Costs of Service Delivery. Washington, D.C., The Urban Institute, 1984. Readers might also be interested in the Revised Data System Manual, 1983, available from the Urban Institute library.

[2]Moore, Kristin A. and Burt, Martha R. Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing. Washington, D.C.: The Urban Institute Press, 1982.

pregnant or had at least one baby. However, all programs were actively involved in secondary prevention--trying to prevent second births to clients in their programs.)

Issues of relevance to public agency planners and funders include:

Where to locate the program? Should the program be located in a local welfare/social services department, a school, a hospital, a family planning clinic, a community center, a free-standing special program, etc.? Does it make any difference where the program office is located?

How to structure the program? Should all services be under one roof (on-site)? Can you succeed if you do almost all services by referral to other agencies (mostly off-site)? Is case management helpful? Is it critical?

What services to offer? Health, education, social services, day care, counseling (what kinds), transportation, etc.? What are "comprehensive services"?

How much will it cost? How much does each service cost, on the average? Which costs are optional, and which are entitlements that the teenager could get even without the program? How should you think about "cost-effectiveness"?

What start-up time, management issues and technical assistance needs should you anticipate? How long do programs need for planning, getting all the necessary interagency agreements in place, reaching a full complement of clients, etc.? Who should they count as clients? What reporting requirements will they have to meet? How are records and case files to be maintained, and what should go in them? What kinds of start-up and ongoing management help will they need?

Which clients to recruit? Age, school status, pregnancy or parenting status, welfare status?

Method

Twenty-one programs funded for 1982 by the Office of Adolescent Pregnancy Programs-DHHS (OAPP) supplied client data for this analysis. We also collected detailed information on unit costs of services in eight programs, seven of which are included in this analysis. The biggest advantage of this data set lies in its having roughly the same data, defined in uniform ways and recorded in uniform format, from many projects with otherwise quite individual

configurations. Because all OAPP-funded projects operated in the context of P. L. 95-626, all were constrained to offer some form of the ten core services mandated in the legislation. Many also offered one or more of the legislation's four supplemental services.[3]

Projects were located in large and small urban areas and in rural areas in all parts of the country. A range of agencies served as primary delivery sites, including schools, hospitals, other health agencies and special adolescent pregnancy programs.

Projects had an average active caseload of 300 female clients, and ranged in size from 50 to more than 700 clients. Our analyses are based on 1054 clients entering a project pregnant or with a baby, and having at least one follow-up after the baby's birth. This sample constitutes 27 percent of pregnant or parenting adolescents who ever entered the programs. From client records we recorded client entry characteristics, service delivery data, pregnancy outcome data and follow-up data on repeat pregnancies, educational and vocational achievement, employment and welfare status for all clients.

This evaluation also offered a rare opportunity to assess the costs of teen pregnancy and parenting programs. Because programs were legislatively mandated to provide a core set of similar services, whether directly or by referral, we were able to come close to estimating a price for the same set

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[3]The ten core services were: 1) pregnancy testing and maternity counseling; 2) family planning counseling and services; 3) primary and preventive health care (which we defined as related to the pregnancy); 4) nutrition counseling and services; 5) venereal disease counseling and services; 6) pediatric care; 7) family life/parenting education; 8) educationaland vocational counseling and services; 9) adoption counseling and services; 10) other health care. The supplemental services were: 1) child care; 2) consumer/homemaker education; 3) counseling for partners and extended family; 4) transportation.

of services across different programs regardless of their service structure. The programs for which we collected financial data were all fully operational, had significant numbers of clients who had been with the programs for a reasonable length of time, and varied as to their program model, sponsoring agency, geographical location and types of clients.

Four days were devoted to collecting financial data at each program. We met first with program staff to learn which services were delivered on-site, what agencies were responsible for off-site services, and how services were paid for. For the on-site services, we determined what made up a typical "dose" of the service, what professional delivered the service, and how often a client typically received the service. Where flat fees were available (e.g., pregnancy testing), we used those figures; in other cases we computed a unit cost based on staff time, overhead, and related expenses. We then telephoned or visited the collateral service agencies to gather comparable information for the off-site services. These data gave us the ability to determine unit costs for each service, including in the calculations direct costs, overhead costs, and, for counseling services, the preparation time of professional staff prior to direct contact with the client.

Program Location, Structure and Services

The data presented in Table I answer the question, "Do characteristics of the programs themselves make any difference for the types or amounts of service their clients received?" The answer to this question is "yes." Program characteristics accounted for between 14 and 31 percent of the variance in services received (see row marked "R^2" at the bottom of the table).

Table I presents an analysis of program characteristics affecting the amount of services delivered to clients in 21 OAPP-funded programs. The

TABLE 1: PROGRAM FACTORS AFFECTING SERVICES DELIVERED

(Unstandardized Regression Coefficients, N = 1054, Clients entering pregnant or with a baby and having at least one follow-up interview)

	SERVICES (DEPENDENT VARIABLES)						
INDEPENDENT VARIABLES	Family Planning	Education/Vocational Counseling and Services	Health Services	Life Skills Development	Supportive Services	Total Service Units[a]	Total Number of Core Services[b]
PROGRAM CHARACTERISTICS							
Urban-Rural (rural = higher)	- .038	- .110+	- .346+	- .300*	- .196+	-1.179**	- .330*
Model							
Single Site (1 = single site, 0 = all others)	.834***	.466+	2.839***	1.082*	.217	5.740***	3.837***
Network (1 = network, 0 = all others)	1.318***	.819**	2.713***	.984+	- .475	4.735**	3.350***
School (1 = school, 0 = all others)	1.623***	.273	6.510***	2.805***	1.783**	11.854***	7.983***
Delivery Site							
Hospital (1 = hospital, 0 = all others)	-1.878***	.595***	-4.826***	-1.285***	- .512+	-4.103***	-4.758***
School (1 = School, 0 = all others)	.709**	.598*	.694	1.060*	.946*	3.607**	2.302***
Other Health (1 = other health, 0 = all others)	- .280	.187	.233	- .114	- .194	- .019	- .232
Special Program (1 = special, program, 0 = all others)	.022	.347+	1.903***	.831*	1.002***	4.496***	1.649***
Percent of Caseload Who are Pregnant	.243***	.116**	.680***	.449***	.381***	1.723***	1.031***
Percent of Services Delivered On-site	- .108	.060	- .276	.202	- .229	- .013	- .535*
Case Management (higher = more)	.109*	.097+	- .088	.270**	.013	.490+	.211+
Length of Follow-up Commitment (higher = more)	- .783***	- .357***	-2.652***	- .687***	- .678***	-4.714***	-2.931***
Intercept	1.580	- .020	6.171	-1.770	2.691	6.704	7.106
R^2	.170***	.152***	.282***	.189***	.144***	.254***	.308***

+ = $p \leq .05$
* = $p \leq .01$
** = $p \leq .001$
*** = $p \leq .0001$

[a]This score sums up the total number of service units of all services, core and supplemental, a client received. Six hours of nutrition counseling would count as six units, three months of day care as three units, etc.

[b]This score counts whether or not a client got any of each core or supplemental service. It measures the diversity or comprehensiveness of service delivery. Its range is 0 to 17. A client who received no services would score 0. A client who received some services in each of four core service areas would get a 4, etc.

table gives the regression equations, using unstandardized regression coefficients, for the following groups of services (all but the last are based on the sum of all service units of that type that each client received):

> Family Planning Services--contraceptive counseling, prescription and nonprescription contraceptive devices, natural family planning instruction, and counseling around issues of sexual decision making;
>
> Educational/Vocational Services--counseling, referral and services, including public school, special schools, GED programs, vocational education and job training;
>
> Health Services--pregnancy testing, maternity counseling, prenatal care, childbirth education, other primary and preventive health care, venereal disease counseling, testing and treatment, pediatric care, and other health care;
>
> Life Skills Development Services--nutrition counseling and education, WIC, Food Stamps, school lunch and breakfast programs, family life education and counseling, parenting education, consumer/homemaker education and counseling;
>
> Supportive Services--adoption counseling and referral, child care and assistance to find child care, counseling for male partners and extended family members, transportation;
>
> Total Service Units--the total number of service units a client received in any core or supplemental service (e.g., ten months of WIC counts as ten units of nutrition service, three months of school counts as three units of education service, etc.), summed across all core and supplemental services--<u>this is a measure of service intensity</u>;
>
> Total number of core or supplemental services in which a client received at least one unit--if a client got anything within a service type, the client received a score of "1" for that service type; if the client got no service within a service type, the score was "0." The higher the summed score on this variable, the more core or supplemental service types the client got at least one service from--<u>this is a measure of service diversity</u>.

Summarizing the effects of program characteristics, rural project delivered fewer services of most types and fewer services overall. This finding probably reflects the fact that rural areas typically are less service-rich than their urban counterparts. It should not be taken to mean that programs in rural areas should receive a lower funding priority. To the contrary, funding

programs in rural areas would probably create a greater proportional increase in the area's available services than funding an urban program, even if each client would still receive somewhat fewer services.

The next three variables--single site, network and school-- represent program model, or the way services are organized. The analysis compares each variable against the other two and against hospital-sponsored projects. The positive coefficients for the three model variables suggest that non-hospital programs of several varieties all delivered more services of most types and more total services than did hospital projects. This pattern is borne out in the next set of variables describing the actual location of primary service delivery--hospital, school, other health agency, and special adolescent pregnancy program (a program set up especially and exclusively to serve pregnant and parenting teens). Here, the "hospital" variable produced negative effects on all but one type of service, rather strongly indicating that hospital-based programs did not do as well as other programs in delivering services to pregnant and parenting teens.

While some programs based in hospitals (but not in our sample) have been able to develop effective comprehensive services, our experience is that it takes hospitals longer, that coordination across hospital departments (OB/GYN, pediatrics, family planning, medical records) is frequently difficult, that someone of very high status (i.e., a doctor) has to care a lot and work very hard to create an effective program, and that the investment to make this happen can be quite substantial. Since programs based in other locations appear to be equally if not more capable of delivering services, including health services, we believe funders would be better advised to support non-hospital programs with good interagency linkages to their local hospitals,

unless there are clear indications that the initiators of hospital-based programs have extraordinary energy and commitment.

Other aspects of program structure also affected service delivery. The percentage of a program's services delivered on-site appears to affect the diversity of services delivered. The higher the percentage of a program's services delivered on-site, the lower the diversity--clients did not get as many different kinds of services. Equally important, whether or not a service was given on-site or off-site does not affect service intensity (the total amount of service units received), nor does it affect the amount of different types of services, as shown in Table I.

Taken together with the finding that single sites, networks, and school programs all succeeded in delivering a range of services to clients, the finding that programs with a high percentage of their services delivered off-site by referral to other community agencies had as good or better a track record of service delivery as those which gave all services to clients under one roof has important implications for funding agencies. In conjunction with case management, which the data in Table I also indicate made a difference for the amount of services a client received, any program structure, model or delivery site can work as well as any other, although some arrangements may take longer to achieve full operation than others. We discuss case management in some detail below. The key for a good program lies more in competent management and good community relations and coordination than it does in specific structures or models. We will address these issues after looking at program clients and service costs.

Program Clients

The higher the percentage of a program's active caseload who were pregnant

at any given time, the more services that program delivered. This finding reflects the fact that girls who entered these programs pregnant received more services than did those coming in as entry mothers. The only other client characteristic affecting the amount of services received was welfare status. Girls on welfare at program entry received more services than those who were not. Client age, race, school status, and number of previous pregnancies or children did not affect the number or type of services received. One might wonder whether ~~this finding represents the way we might~~ want programs ~~to~~ run--perhaps younger girls, or dropouts, actually need more services, as might girls with ~~m~~ children, or who have experienced multiple pregnancies in rapid succession.

A final indicator of the importance of pregnancy status is the effect of the last variable in Table I, length of follow-up commitment. The shorter the length of follow-up, the more services of all types clients received. This suggests that some programs concentrated their energies on services during pregnancy and immediately thereafter, and did not focus very much on client needs during the parenting period. Service planners and funders need to think carefully about this pattern, and whether it should be supported or altered. On the one hand, if girls are most likely to attend the program while pregnant, staff may be correct to try to give them as much as possible before they stop coming. On the other hand, pregnant girls may be less likely to absorb critical lessons in parenting and child care than a mother with a 6 month old baby to manage. In addition, the serious coping problems for teen parents come after the baby is born. If program support stops shortly after birth, programs may be missing the best opportunities for helping young

mothers to maintain performance in all of the conflicting roles they face (mother, student, teenager and possibly worker).

Service Costs

Table II gives the unit of measurement for each type of service, and the average unit cost in the programs we visited. It also gives the range of costs. Unit costs under $10 for counseling services usually reflect group administration of those services. Some of the cost variations presented in Table II arise due to the cost of living in the program's geographical location. Others reflect local philosophy toward public welfare services. The big ticket items of prenatal care and delivery, education, job training, AFDC and licensed child care show very great variation, due to both of these causes. Since these will in large part be fixed within any given service planning region, readers can make their own estimates for these items based on local anticipated costs.

In Table III we have transformed the unit cost figures into the likely cost for the first 12 months after program entry of several different service configurations--three for girls entering a program pregnant, and two for girls entering with a baby (entry mothers). The footnotes of Table III detail our assumptions about the number of units of a given service. Readers thus have all the information needed to modify any assumptions and calculate anticipated costs given their own assumptions.

The service packages in Table III do not include every service. Rather, we based our decision whether or not to include a service on the service delivery data from the 21 programs we evaluated. If 25 percent or more of program clients of a given type (pregnant vs. entry mothers) received the

Table II

Unit Costs of Core and Supplemental Services

Services	Definition of a Unit	Average Unit Cost	Range in Unit Cost
Pregnancy testing	1 test	$ 10	$ 7-14
Maternity counseling	1 hour	18	11-14
Family planning couns.	1 hour	18	14-26
Prescription device	1 prescription	24	8-36
Non-prescrip. device	1 device	2	2
Nat'l fam. plan. instr.	1 hour	15	17-28
Sexual decis.-mkg couns.	1 hour	15	2-25
Prenatal care/deliv.	whole package	1952	1300-2470
Childbirth education	1 hour	3	2-5
Nutrition couns. & ed.	1 hour	16	2-23
Brkfst or lunch prog.	1 month	38	25-65
WIC	1 month	32	20-44
Food Stamps	1 month	42	25-47
VD test	1 test	12	11-13
VD treatment	1 episode	6	2-18
VD counseling & educ.	1 hour	28	14-39
Pediatric care	1 visit	25	17-40
Fam. rela/parenting ed.	1 hour	7	2-19
Educa. & voca. couns.	1 hour	21	8-36
Education/school	1 month	319	174-392
Voc. ed./Job training	1 month	356	103-840
Adoption counseling	1 hour	28	20-45
Assist/find child care	1 hour	17	8-26
Child care-licensed	1 month	235	146-337
Child care-private/fam.	1 month	134	125-142
Consum/homemkr educ.	1 hour	5	2-19
Couns.-ext. fam. memb.	1 hour	18	10-22
Couns.-male partner	1 hour	18	8-24
Transportation-regular	1 month	28	18-44
Personal counseling	1 hour	19	8-25
AFDC-extra child only	1 month	56	5-84
AFDC-3-person unit	1 month	267	60-436
Assist/find housing	1 hour	20	19-21

Table III

Entitlement and Extra Service Costs, Depending on Type of Client

	TYPE 1[a]		TYPE 2[b]		TYPE 3[c]		TYPE 4[d]		TYPE 5[e]	
Services	Entit.	Extra	Entit.	Extra	Entit.	Extra	Entit.	Extra	Entit.	Extra
Pregnancy testing		10		10		10				
Maternity counseling		18		18		18				
Family planning couns.		18		18		18		18		18
Prescription device	24		24			24	24			24
Non-prescription device										
Nat'l fam. plan. instruc.										
Sexual decision-mkg. couns.		15		15		15				
Prenatal care and delivery	1952			1952		1952				
Childbirth education		15		15		15				
Nutrition couns. & educ.		80		80		80		80		80
Breakfast or lunch prog.										
WIC	384		384		384		384			
Food Stamps			252		504		504			
VD test		12		12		12				
VD treatment										
VD counseling & educ.										
Pediatric care	150		150			150	150			150
Fam. rela/parenting educ.		35		35		35		35		35
Educa. & voca. counseling		21		21		21		21		21
Education/school	2871		2871		2871		2871		2871	
Voc. ed/job training										
Adoption counseling										
Assist/find child care										
Child care-licensed								2115		2115
Child care-private/fam.										
Consumer/homemaker educ.										
Counseling-ext. fam. memb.		18		18		18		18		18
Counseling-male partner										
Transportation-regular		168		168		168		168		168
Personal counseling		19		19		19				
AFDC-extra child only	392									
AFDC-2-person unit			1602				3204			
Assist/find housing										
Column Totals	5773	429	5283	2381	2871	2555	7137	2455	2871	2629
Totals for "Types"										
(% that is entitlements)	6202 (93%)		7664 (69%)		5426 (53%)		9592 (74%)		5500 (52%)	

a. Type 1 = 12-month costs for a pregnant teen living in an AFDC family at program entry, who delivered after 5 months in the program, had all medical care covered by Medicaid, 12 months of WIC, 6 pediatric visits, 9 months of school, 7 months of "extra child" AFDC but no "extra" Food Stamps, 5 hours each of childbirth, nutrition and family life education, 6 hours of assorted counseling, 6 months of transportation, and miscellaneous other services.

b. Type 2 = 12-month costs for a pregnant teen not on AFDC at program entry, who delivered after 5 months and went on AFDC one month after giving birth. Medicaid covered pediatric and family planning costs, but the program covered prenatal care and delivery. Had 6 months of AFDC and Food Stamps for a 2-person unit. All other assumptions identical to Type 1.

c. Type 3 = 12-month costs for a pregnant teen who never received AFDC during that 12 months and was ineligible for WIC, Food Stamps and Medicaid. Program covered medical costs. All other assumptions identical to Type 1.

d. Type 4 = 12-month costs for an entry mother who was her own 2-person AFDC household during the entire 12 months, had all medical care covered by Medicaid, received 12 months of WIC and Food Stamps, 9 months of licensed child care at program expense, 5 hours each of nutrition and family life education, 3 hours of assorted counseling, 6 months of transportation.

e. Type 5 = 12 month costs for an entry mother who never received AFDC during that 12 months and was ineligible for WIC, Food Stamps or Medicaid. Program covered family planning and pediatric care costs. All other assumptions identical to Type 4.

service, we have included it. (Thus, Table III also gives the reader an idea of what clients in these programs typically received.)

Service costs in Table III are divided between those to which a client is entitled if she meets eligibility requirements (e.g.,AFDC, Medicaid payments for medical care, Food Stamps, public school) and "extra" services provided by a teen pregnancy and parenting program. For medical services, we have assumed that if the client has no Medicaid coverage, the program picks up the cost of prenatal care and delivery, pediatric care, etc. If one assumed some other source of funding for this medical care, the special program costs would shrink considerably.

Table III reveals that depending on client type, the total cost for 12 months of support to a pregnant or parenting teen varies between $5283 for a non-AFDC teen who entered the program pregnant and delivered in the program (delivered clients) to $9592 for an entry mother on AFDC. Costs for entry mothers include child care whereas those for girls delivering in the programs do not; this is because these programs gave child care to approximately three times the number of entry mothers as they did to delivered clients.

Even more important than absolute cost is the comparison between what clients were entitled to and what they got "extra." Costs for entitlement services ranged from lows of 52-53 percent for never-on-AFDC delivered clients and entry mothers (Types 3 and 5), to a high of 93 percent for a girl who entered the program pregnant and on AFDC. Some clients might not use all of their entitlements (e.g., they may be school dropouts), but the policy issue of whether to spend the money for these services if the client uses

them has already been decided in the affirmative. Therefore, the remaining policy issue is whether to commit resources to the "extra" services.

To get a handle on what these data mean, think of the potential return on the investment in the "extra" services (because, after all, the public would most likely have to pay for the entitlement services with or without the program). Suppose, for a girl of Type 1, the $429 invested in program services during the first 12 months meant that she remained in or returned to school, got a GED or high school diploma, was less likely to abuse or neglect her child because of good parenting education, delayed subsequent childbearing, and was able to become self-supporting two to three years after entering the program. The "extra" $429 would be a pittance when compared to saved future welfare costs, reduced likelihood of a child protective services case, etc. The "cost-effectiveness" prospects for clients of Types 2-5 are not as dramatic (assuming that the program pays medical costs), but they are still well worth the savings in AFDC costs alone, given even a two to three year time perspective, if a program can help its clients achieve important outcome objectives before they become long term cases.

Project Implementation and Management

Our experience with this evaluation, which in its fullest extent included 26 grantees and 38 separate program sites, left us with some impressions which might be valuable to people in public agencies who want to plan, promote and fund services for pregnant and parenting teens. These impressions cover the need for adequate lead time to develop interagency coordination; the need for adequate case management, client records and client tracking; and the need for greater emphasis on services to parenting teens.

Interagency Coordination. It appears that problems with initial, and sometimes ongoing, interagency coordination are endemic to adolescent pregnancy programs. This happens because the appropriate service approach for pregnant teens and teen mothers requires coordination of at least three service sectors in the community which typically operate autonomously: the medical system, the school system, and the social service system. It takes a lot of meetings and discussions to work out whether, and how, these agencies will change their standard operating procedures to accommodate increased interagency flow of clients, information and money. Time is therefore a critical ingredient--time to discover all the problems that coordination will inevitably produce, and time to find satisfactory solutions. When community agencies have not held these discussions prior to receiving funds, they must do so afterwards if they want their clients to have access to services other than those they provide themselves. However, allowing sufficient time for coordination becomes difficult after the money is in because of internal and external pressures to hire staff and to start delivering services.

Any funder with the goal of assuring that individual clients benefit from a full range of services without duplicating services or having clients fall through the cracks must face the issue of whether to fund initial (and necessary) planning activities that assure interagency coordination. Also, whether or not a funding agency explicitly supports planning activities, it would be helpful if it provided specific guidelines and technical assistance to both prospective and actual program staff about what interagency coordination really requires. This includes help in getting agencies to work together in ways that differ significantly from standard operating procedures.

Options funding agencies may wish to consider are:

1. Only fund programs that provide clear evidence that they have resolved agency coordination problems. Indicators of full coordination are agreements and mechanisms in place to share information about individual clients, to assign case management responsibility, to refer clients to appropriate agencies, and to pay for the services each agency will provide.

2. Fund planning grants so that community agencies can devote adequate time and effort to program development and coordination. These should be low-cost, one-person-year efforts.

3. Provide clear guidance to prospective programs about the practical meaning of interagency coordination, and give both prospective and actual programs technical assistance to achieve it.

4. Examine practices of the funding agency itself that could hinder or facilitate strong program development, such as requirements to approve arrangements, (in)adequate response time, flexibility to respond to local conditions.

Case Management. We would argue that to expand the availability of and access to comprehensive services, programs must both assess their clients' individual needs and provide or arrange for services to meet those needs. Such an approach demands active rather than passive involvement with clients. It means that a program does more than simply tell clients about its services and hope that clients get to them. Someone must assume responsibility for monitoring individual cases to make sure that clients get available services according to their needs. (Of course, clients always have the option of refusing services.) As we saw from the data in Table I, the more agencies pursue active case management, the more services their clients receive.

Attention to assigning case management responsibility is important for all types of service models. Even when all the services are available at a single site, some mechanism should be in place to make sure that individual clients get the services they need. One might think this would happen automatically, but we have seen single-site programs where it was impossible to tell everything a client was getting without going to five different sets

of case files. To the extent that case management records document client needs, services to which clients were referred, services they had difficulty in getting, and needs for which no services existed, the process also serves as a stimulus to service development, to fill in the gaps in the community's system of care.

Although we believe that it is tremendously important for programs to develop case management mechanisms, we would anticipate substantial variations among programs in how they organize case management. Funding agencies might consider funding a variety of case management models in order to test their relative effectiveness and efficient use of resources. The basic ingredients of a case management mechanism, whatever its structure, are:

1. A way of identifying all clients served by the program;
2. A system for assigning each client to a case manager who will have the responsibility for assuring that she gets the services she needs;
3. A means of determining which services the client needs, with periodic reassessment;
4. A method for confirming receipt of services, both through the program and by referral agencies. (Failure to receive services within a reasonable time should trigger an inquiry as to where the system is falling down--did the client fail to keep an appointment, did the referral agency lose the record, etc. If the fault lies with the system, action can be taken to correct the problem for the future.)

Everything we have said about case management implies an adequate record-keeping system. Attention paid to keeping good records has an additional payoff--the program can respond much more easily to requests for information from the public or potential funders, and can also compile required reports with greater ease. Initial program response to the recordkeeping system designed for our evaluation was moans and groans, but almost all still use either the original system or an adaptation of it years after the evaluation.

They report that it has made their activities clearer to themselves and has simplified submission of routine reports to funders.

Program Clients, Revisited

The federal legislation that funded the programs in this evaluation emphasized pregnancy rather than parenting, and health care rather than the many other types of service needed (although it did include a quite extensive list of other services). This emphasis created programs in which approximately 75 percent of the clients entered pregnant, services tended to concentrate on the health care needs of the pregnancy, and pregnant clients received more services than entry mothers. Further, quite a number of programs did not plan, at least initially, to maintain contact with or provide assistance to their clients after a relatively short follow-up period of 6 weeks to 6 months. Our impression, gathered from many program directors, is that the pregnancy period does not make as many new demands on their clients as does coping with actual mothering, yet the supports for teen mothers to assume and successfully combine their new roles were fewer. It seems important to us that programs take seriously the needs and difficulties of the teen parent as well as the pregnant teen, and create program services that will help them through the adjustments they must make while providing maximum support for them to begin or continue school or other activities that will promote eventual self-sufficiency.

Another underserved group is school dropouts. Recent evidence suggests that as many as 40-50 percent of female school dropouts involved pregnancy and/or marriage. In addition to that figure, program experience indicates that many girls who are failing in school drop out and then become pregnant. The programs in this evaluation did not specifically target school dropouts,

but 25 percent of pregnant clients and 43 percent of entry mothers were dropouts at program entry. Programs were not very successful in helping these clients return to school, although they did help them with other concerns. This population might be worth a special focus at a state or local level.

Conclusions

We have described the impact of program structure on a program's capacity to deliver services to pregnant and parenting teens, have looked at the variety of services offered and their costs for different types of clients, and have detailed a number of important issues in program planning and execution. In the process we have made a number of suggestions for public agency program planners and funders. Rather than repeat the main points of those sections here, we would prefer to close with a word about evaluation--or at least about data collection.

The existence of a large, multi-program evaluation, based on a uniform data recording and collection system used in all programs (but fitted to individual program needs and pre-existing systems), has enabled us to make the statements in this article. Less, but still important, information can be gleaned from very simple recording systems. However, one drawback of most program data lies in its noncomparability--different programs collect different information, in different categories, at different points in a client's history with the program and pregnancy/parenting sequence.

Large public funders of many teen pregnancy and parenting programs could contribute significantly to increasing knowledge about how to run these programs, and for whom, if they would require reporting of some minimal but uniform data set as part of a program's grant obligations. Requiring that

programs "do an evaluation" is fine, but it does not usually result in the funder receiving comparable information from all funded programs. Agreement on a basic set of client entry characteristic data (we used age, race, school and welfare status, previous pregnancies, number of children and living arrangements) would help, as would a basic set of services and definitions for service units, whether or not every program delivers every service. Equally important is agreement on uniform data collection points (e.g., at program entry, at the birth of a baby, 12 and 24 months postpartum).

Several states have already adopted uniform minimum reporting systems. The more such data become an automatic part of programs' quarterly or annual cycles, the better our grasp on our activities will become.