Approved 1-30-86
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn, Chairperson, at 1:30 a.m./p.m. on January 23, 1986 in room 423-S of the Capitol.

All members were present except:

Representative Williams, excused.

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Research
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Ms. Aileen Whitfill, Executive Assistant for Policy & Program Development, SRS.

Visitor's register, (see Attachment No. 1.)

Chairman called meeting to order, asking members to give their attention to minutes of January 16, 1986. Rep. Foster moved these minutes be approved, seconded by Rep. Harder, motion carried. Chair then called attention to minutes of January 21, 1986. There were suggested corrections. The words "Altzheimers legislation" changed to "Altzheimers concerns". To correct bill number HB 2498 to HB 2492 when used in explanation of the bill on page 2. In second paragraph under HCR 5015, change wording from "may" to "shall" when speaking of consideration of HB 2498.-- and HB 2533. With suggestions for these changes, Rep. Hassler made a motion for said changes on minutes of January 21, 1986, seconded by Rep. Runnels, motion carried. In regard to minutes in general for January 21, 1986, Rep. Hassler moved they be approved as modified, seconded by Rep. Pottorff, motion carried. Further, Chair called attention to minutes of January 22, 1986. Rep. Green moved these be approved as written, seconded by Rep. Bryant, motion carried.

Chair called attention to HB 2208. It has been brought to his attention that when HB 2208 was put on calendar last year the committee report was erroneously overlooked. Chair read from a document drawn up by the Revisor, Mr. Furse to correct this. It reads, "Mr. Speaker, your committee on PH&W recommends that HB 2208 (as amended by House PH&W be amended by adoption of the amendments recommended by the House Committee on Public Health and Welfare during the 1985 legislative session and the bill be passed as amended.)

Chair stated he is just alerting members that this will be read on floor of House and will clear up process of getting HB 2208 through the House.

Chair then introduced Ms. Aileen Whitfill, of SRS and she began her presentation.

Ms. Whitfill had distributed handout to members, (See Attachment No. 2), quite a large report. She indicated charts and tables and statistics during her presentation.

The report is entitled, A KANSAS AGENDA FOR INVESTING IN WOMEN AND CHILDREN, Dec. 1985.

Some of the data is alarming she said in that indications are made that Kansas ranks 18th in infant deaths. In a 30 year period, our state dropped from 18th to 30th. This is an alarming statistic. Poverty among single mothers and children is directly related to this statistic. She touched on many topics, i.e., Increases in poor single parent families, increases in births to unmarried teenagers, inadequate level of publicly funded day care, unpaid child support, lack of job training, having more children increases the likelihood of dependence on public assistance.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

She continued, speaking to the concern of significant societal costs of poverty among single mothers, i.e., low birthweight infants, child abuse and neglect, alcoholism and depression. She cited statistics of low birthweights of Kansas and United States.

Problems associated with low birthweight and women most likely to have low birthweight infants were addressed, and how prevention of these low birthweight infants can be done, thus eventually costing the state less dollars. Prenatal care is most important, and she cited costs of doctor's visits, nutrition education, family planning among services that need to be offered. Ms. Whitfill then spoke of day care being made available, job training, and other services have been affected by cuts in budgets, both State and Federal cuts.

Further, she spoke to cost effective strategies for decreasing dependence on public assistance among single mothers, and ameliorating the effects of their poverty. She stated this report today cannot provide all the needed information needed to solve such immense problems of the poor female headed families. There were four strategies that could be pursued, i.e., provide special employment programs, expand the number of poor pregnant women who receive prenatal care, provide services to ADC clients and other high risk groups designed to prevent child abuse and neglect, and develop programs in conjunction with H. & E. and Dept. of Education to help prevent unintended pregnancies.

Provide special employment programs for ADC mothers of children under six, provide day care for these women. Expand number of low-income pregnant women who receive prenatal care, and expand number of children who receive early and periodic screening, diagnosis, and treatment services, provide services to ADC clients and other high risk groups designed to prevent child abuse and neglect, increase access to family planning, help establish school-based clinics, provide specialized caseworkers, increase ADC benefit levels, continue to expand child support enforcement programs.

Ms. Whitfill answered numerous questions from members, and it was the consensus of all, there is much to be done in order to save money in the long term.

Chair thanked Ms. Whitfill for her most interesting and comprehensive remarks.

Meeting adjourned at 2:35. Next meeting scheduled for Monday, January 27th.

GUEST REGISTER

DATE 1-23-86

HOUSE

PUBLIC HEALTH AND WELFARE

date 1-23-86

NAME	ORGANIZATION	ADDRESS
[illegible] Whitfield	SRS	Topeka
Larry Hinton	SRS	Topeka
Theresa Shively	Kansas NARAL	Topeka
Barbara Reinert	Planned Parenthood of KS	Topeka
Lynn Barclay	KCSL	Topeka
[illegible] Whiteman	Leg.	
Laurie Hull	KACMAA	Topeka
Anne Moriarty	National Org. for Women	"
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Belva Ott	Planned Parenthood of Kansas	Wichita
Darlene Stearns	Consultation of Churches	Topeka
[illegible] Young	KDHE	Topeka
Paul Klotz	Assoc. of CMHC's of Ks, Inc.	Topeka
Joan [illegible]	Ks. Advocacy [illegible] Ser.	Manhattan
[illegible] Wilkin	Girl Scout	Topeka
Ruth [illegible]	—	Topeka
Loretta Class	United Way	Topeka

Attachment 1
1/23/86
Hs. PHW

atlm. #2
1-24-86

A Kansas Agenda For Investing In Women And Children

December 1985

OFFICE OF ANALYSIS, PLANNING AND EVALUATION
KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

atlm #2
Hs. PHW 1-24-86

A KANSAS AGENDA FOR INVESTING IN WOMEN AND CHILDREN

DECEMBER, 1985

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SECRETARY
ROBERT C. HARDER

EXECUTIVE ASSISTANT FOR POLICY AND PROGRAM DEVELOPMENT
AILEEN C. WHITFILL

The Office of Analysis, Planning, and Evaluation is directed by Aileen C. Whitfill. The Chief Analyst is Mark Levy. The Management Analysts are Stephen Ferrier, Allyn Lockner, and formerly Stephen Schiffelbein. The Secretary is Bonnie Still. Mark Levy had lead responsibility for this report. Stephen Schiffelbein and Stephen Ferrier also contributed.

Attm #2
1-24-86

READER'S GUIDE

This study can be used in different ways by readers with different needs. Readers interested in a detailed review of a wide range of data on policy issues relevant to women and children living in poverty should read the entire document. Readers interested in detailed information on only certain topics, such as employment programs, can use the table of contents to find background information, information on current Kansas programs, information on programs in other states, and information about policy proposals related to that topic throughout the report. The Executive Summary provides a brief introduction to all the topics in the report, and can be used by readers who are unsure of which parts of the report are of interest to them.

A KANSAS AGENDA FOR INVESTING IN WOMEN AND CHILDREN

EXECUTIVE SUMMARY

Poverty among single mothers and children has become a critical national concern. As the following table shows, one of every four pre-school children nationally were in poverty in 1983, and that poverty rate is far greater than for older children and adults.

1983 National Poverty Rates

Pre-School Children	25 out of every 100
School-Age Children	21 out of every 100
Elderly Adults	14 out of every 100
Non-Elderly Adults	12 out of every 100

The national poverty rate for all children rose from 14 out of 100 children in 1969, to 16 out of 100 in 1979, and to 22 out of 100 in 1983. According to the Congressional Budget Office the severe increase in poverty among children from 1979 to 1983 was likely the result of back-to-back recessions, rapid inflation in 1979 and 1980, and reductions in income maintenance programs.

Comparable Kansas data on the rise in poverty among children does not exist, but the 1980 Census shows that at least 73,000 Kansas children lived in poverty even after counting their public assistance income. Based on the national trend, that figure is probably over 100,000 today. Kansas provides Aid to Dependent Children benefits to less than half these poor children.

Clearly one way to address the issue of poverty and children is to address the special problems of female headed households. At the direction of the Secretary of the Department of Social and Rehabilitation Services this study assesses some of the factors that contribute to poverty among single mothers, assesses some of the negative consequences of that poverty, assesses the major programs in Kansas currently addressing those problems, and describes some of the innovative programs in place around the country that are attempting to reduce poverty among female headed households. The special problems of and programs for single teenage mothers are also addressed. Finally, strategies for addressing these problems in Kansas are recommended.

While SRS recognizes the difficulty of marshaling the resources needed to address this problem, we believe that effort must be made. We have an obligation to do what we can to reverse the rise in child poverty and to decrease welfare dependence. Failing to make this investment in children is extremely shortsighted. If we do nothing, the costs in terms of crime, alcoholism, child abuse and neglect, low birthweight infants, and future dependence on public assistance will be great. An intensified effort to help the State's poor children is in the self-interest of all Kansans. Following are some of the key findings of this study and a description of the agenda recommended to begin facing the problems of children in poverty.

Some Of The Significant Factors That Contribute To Poverty Among Single Mothers

- **The increase in poor single parent families.** The percentage of children living with one parent nationally increased from nine percent in 1960 to 19 percent in 1978, and this figure is projected to be 25 percent by 1990. Single parents are much more likely to be in poverty. In Kansas in 1980 one-third of female headed families were in poverty, compared to one out every ten for all Kansas families. (See pages 3-5.)

- **The increase in births to unmarried teenagers.** Births to unmarried teenagers are on the rise. These mothers are more likely to have more children, less education, more unemployment, and be in poverty than mothers who delay childbirth. An SRS survey of public assistance clients found over half these mothers had their first child as teenagers. (See pages 7-11.)

- **The inadequate level of publicly funded day care.** As female headed families have increased, publicly supported day care services needed to help these women remain independent has decreased. State funded day care slots in Kansas declined from 5,298 in 1980 to 2,481 in 1985. The survey of Kansas public assistance clients found the lack of day care is most frequently cited as the problem that makes it difficult for public assistance clients to work. (See pages 6-7.)

- **Unpaid child support.** Child support payments, needed to keep many single mothers out of poverty, are often not made. Nationally only 47 percent of women who are awarded child support receive the full amount due them. (See page 6.)

- **The lack of job training.** The SRS survey of public assistance clients found that two-thirds of these mothers had no job training and four out of every ten had not completed high school. A review of SRS jobs programs found that two-thirds of the mothers on public assistance are exempt from jobs programs because they have children under six. And almost two-thirds of the non-exempt mothers are not provided services because of inadequate day care capacity or other problems. (See pages 23 and 46-47.)

- **Having more children increases the likelihood of dependence on public assistance.** Single women with more children are less likely to leave public assistance by working, according to a recent Harvard study. Thus, the number of children women have is a critical factor in their ability to escape poverty. Surprisingly the Harvard study also found single women with children under age six are more likely than women with older children to leave poverty by working. (See pages 7 and 10.)

Some Of The Significant Societal Costs Of Poverty Among Single Mothers

- **Low birthweight infants.** Low birthweight infants, which contribute heavily to infant mortality and high-cost medical care for infants, is more prevalent among Medicaid clients (almost 10 out of every 100 births) than among all Kansans (6 out of every 100 births). The lack of adequate prenatal care is an important factor in these low birthweights. (See pages 12-17.)

- **Child abuse and neglect.** Child abuse and neglect occur most frequently among poor families. In fiscal year 1984, over half of all families receiving SRS services to prevent future abuse and neglect were public assistance recipients. (See pages 17-18.)

- **Alcoholism and depression.** National studies indicate that among the types of women most likely to abuse alcohol are never-married women, divorced or separated women, and unemployed women seeking work. Another study found the greatest increases in depression in recent years are among young and poor female heads of families. (See pages 18-19.)

Data On Kansas Aid To Dependent Children Clients Confirm The Impact Of Teenage Childbirth, The Number Of Children Women Have, Education, And Other Factors On Poverty Among Single Mothers

In order to assess the characteristics of Aid to Dependent Children (ADC) clients and factors related to poverty, this study included a statistically valid survey of ADC clients. The key results of this survey are summarized below:

- **Teenage Childbirth and ADC.** A disproportionate number of ADC female heads of households are women who became mothers as teenagers.

- **Teenage Childbirth, Number of Children, Education, and Employment.** ADC clients who became mothers as teenagers are more likely than others to have more total children, not finish high school, and have never worked.

- **The Effects of More Children.** ADC clients who have more children are more likely to have been on ADC for longer periods, have less education, are more likely to have not had a job for longer periods, and are more likely to have difficulty finding day care.

- **The Effects of Education and Job Training.** Education and job training are to varying degrees related to higher earnings in previous jobs and less time since the last job, and ADC clients who completed high school or had job training are far less likely to have never worked.

- **Clients' Lack of Job Training and Education.** Of the surveyed clients, 66.7 percent had never had any job training outside of high school, and 40.5 percent did not have a high school education.

- **Day Care and Transportation Problems.** Day care and transportation problems were cited by clients as the most significant impediments to employment.

These findings are generally consistent with those of national studies. These findings also support the notion that reducing teenage childbirth, reducing family size, increasing job training, and increasing job support such as day care and transportation could contribute to reduced dependence on public assistance. A previously mentioned national study concluded that women with fewer children are much more likely to leave ADC by working. Helping ADC women to limit the size of their families, if they wish to do so, may be the most significant single step SRS could take toward reducing dependency on public assistance. The number of children the ADC clients had was the only variable that appeared to be by itself strongly associated with the number of years they had been receiving ADC. (See pages 21-28.)

Modifying Or Expanding Existing Kansas Programs Can Decrease Dependency And Ameliorate The Effects Of Poverty

The following existing Kansas programs address the problems of poor single mothers.

- **Aid to Dependent Children.** The Kansas Aid to Dependent Children (ADC) program provides income to about 65,000 Kansans in families with children deprived of parental support due to absence, incapacity, or unemployment of a parent. In fiscal year 1985 15,598 or 83.4 percent of ADC households were headed by single women. ADC benefits are also provided to about 600 pregnant women who have no other children, but will be eligible for ADC when their baby is born. Despite the clear value of this assistance, it falls short of need because benefits have not kept up with inflation and maximum benefits (combined with other public assistance) equal only 69 percent of the federal poverty level. (See pages 29-30.)

- **Medicaid and MediKan.** The Kansas Medicaid and MediKan programs provide medical benefits to about 126,000 low-income Kansans. About 18,900 or 26 percent of the Medicaid/MediKan cases include single mothers and their children. Pregnant women eligible for the Aid to Pregnant Women program are also eligible for Medicaid.

  It may be possible to add about 450 children over age five to the Medicaid program with little or no cost to the State by including these children under the so-called Ribicoff rule. This change would bring some new children into Medicaid, costing the State money. But a larger group currently on the state-funded MediKan program would be shifted to the partially federally-funded Medicaid program, offsetting some or all of the State costs for new clients. A similar change that would bring more pregnant women into the Medicaid program is being pursued. (See pages 31-36.)

- **Early and Periodic Screening, Diagnosis, and Treatment, and Family Planning.** Included in Medicaid/MediKan coverage are prenatal care, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children, and family planning. The data indicate Medicaid clients are not fully utilizing any of these available services. Encouraging utilization of these services would be a cost effective way to reduce dependency and ameliorate the effects of poverty. Expanding utilization of family planning services may be particularly cost effective for the State since the federal government reimburses the State for 90 percent of family planning expenditures rather than the usual 50 percent. (See pages 36-37.)

- **Department of Health and Environment Programs.** The Department of Health and Environment operates several programs that work in concert with SRS programs in this area. The Maternal and Infant Care programs provide prenatal and infant care, and parenting education to about 1,800 mothers in ten counties. Of those, 80 percent are single mothers and 60 percent are teenage mothers. The Women, Infants and Children program provides supplemental food and nutritional counseling to about 24,000 pregnant and breastfeeding women and their children. The Healthy Start program provides home visits to about 10,000 new mothers. The visitors provide support for the family, teach parenting skills, and encourage utilization of preventive health services. The Department also operates family planning clinics in 65 counties. (See pages 37-39.)

- **Child Support Enforcement.** SRS collects about $11 million in child support payments for ADC clients and other single mothers. That figure is expected to increase to $22 million in fiscal year 1986 due to changes in the law that include procedures to make it easier to withhold support from paychecks and provide free child support services to non-ADC cases. Despite this substantial progress, there may be as many as 20,000 or more cases for which it may be possible to get child support, but for which SRS does not have enough personnel to pursue. Also, the State of Wisconsin is experimenting with new child support methods that should be watched and considered by Kansas. (See pages 39-41.)

- **Employment Programs.** The primary employment program for poor single mothers is the ADC Work Incentive Program (WIN). The primary services of this program are assistance with job searching and unpaid work experience in public and private non-profit sectors. Of all ADC mothers, 65 to 70 percent are not required to register for WIN because they have children under six, despite the fact studies have shown these young mothers have the best chance of gaining employment compared to women who have been on ADC longer. SRS makes no concerted effort to recruit these women to volunteer, largely because the money to provide needed day care and other support services is not available. Of those required to register over 60 percent are found not job ready and receive no services, most often because of inadequate day care and other services. Some states have successfully included significant numbers of mothers of young children in their WIN program and provided the necessary support services. (See pages 42-48.)

- **Foster Care and Family Services.** SRS programs for abused and neglected children focus on providing services to prevent repeat incidences and foster care placements for children who cannot be safely left at home. Another upcoming study by SRS's Office of Analysis, Planning, and Evaluation will address the cost effectiveness of shifting some family services funds to programs that attempt to prevent abuse and neglect among high risk groups before it happens. Since ADC clients are overrepresented among abuse and neglect cases, ADC clients would be a logical target group for such preventive services. (See pages 50-51.)

- **The Youth Center at Beloit.** The Youth Center for female juvenile offenders at Beloit is relevant to this study because an astonishing 75 percent of its 76 residents are confirmed or suspected victims of abuse or neglect. Also, the young women at the Youth center are high risk candidates for becoming poor single mothers and potentially abusive mothers. The Youth Center provides vocational education and parenting education to help these young women avoid dependency. (See pages 51-53.)

- **Alcohol and Drug Abuse Programs.** SRS grants funds to four community organizations that provide alcohol and drug abuse treatment or prevention services specifically to women. SRS also funds treatment programs for youth and preventive programs in the schools. (See page 53.)

- **Public School Programs.** To varying degrees public schools in Kansas provide parenting education and special programs to help pregnant and parenting teenagers to stay in school. Four Kansas school districts provide particularly extensive programs. For example, six Wichita High Schools have licensed day care centers for the children of students in the schools. (See pages 53-54.)

Innovative Programs Around the Country That Address The Problems Of Female Headed Households In Poverty

States around the country were researched and literature was reviewed searching for innovative programs that address the issues raised in this report. The level of information received about these programs varied, and in most cases was not sufficient to allow evaluations of those programs' effectiveness. The value of these descriptions is that they can provide, in conjunction with the rest of this report, new concepts of how to address the issues of single mothers and poverty. The innovative programs focus on two areas: programs to help teenage mothers and employment programs.

- **Programs For Pregnant And Parenting Teenagers.** Most of the programs that address the teenage childbearing issue use a combination of approaches, the most common of which are family planning and counseling on the benefits of delayed childbirth for teenagers who are not yet pregnant; and parenting education, family planning, prenatal care, day care, and vocational services for pregnant and parenting teenagers. In many instances, case management is provided to counsel teenagers and help them access available services. Also, in many cases services are

provided in the schools to increase accessability and help keep these young women in school.

As one example, the State of Illinois will spend $11 million in fiscal year 1986 on its Parents Too Soon Initiative, which involves ten state agencies and the following major programs.

- The Department of Health funds three demonstration projects, 20 family planning clinics, and 25 prenatal care programs for teenagers. The demonstration projects provide medical, social, and educational services in three areas of the State with high unemployment, high birthrates to teenagers, and high infant mortality.

- The Department of Public Aid has ten specialized caseworkers in Chicago who each serve about 1,000 teenage mothers each year. Caseworkers mail letters to all teenage Aid to Dependent Children clients inviting the clients to an orientation session for the voluntary program. About half those receiving letters came to the orientation session. Those who participate attend three half day workshops on self-confidence, family planning, parenting skills, and home management.

- The Department of Children and Family Services funds 28 community programs designed to prevent unwanted pregnancies and prevent neglect and abuse by teenage parents. The primary services provided by these programs are parenting classes taught in urban areas; home visitors in rural areas who teach homemaking, family planning, child care, and more; and specialized day care to help mothers complete education and training programs. (See pages 55-59.)

o **Employment Programs.** Common elements among the innovative employment programs in other states include more extensive on-the-job training and other training opportunities than in the Kansas Work Incentive Program, and more extensive support services such as day care and transportation. For example, the National Supported Work Demonstration showed that intensive supported work programs can effectively move long-term ADC clients into jobs. Supported work includes close supervision during on-the-job training by employment program staff, peer group support by working in small groups, and graduated stress that provides increasing productivity demands as the client gains experience.

  As another example, Massachusetts has an unusually extensive array of services for its Aid to Dependent Children/Work Incentive Program clients. The program, called CHOICES, is also distinctive in that it recruits volunteers among normally exempt women with children under six. About 20 percent of the participants are WIN exempt clients. The services offered are different from Kansas in two ways. First, higher education, supported work operated by community agencies, and vocational education are provided to 23 percent of the clients. These services, that have potential for allowing clients to get higher level jobs that will pull them out of poverty, are not available in Kansas' WIN program.

Massachusetts officials report higher job placement and retention rates than in their previous WIN program. The second difference is that the CHOICES program includes extensive day care and transportation assistance that comprises 40 percent of the program's budget. The volunteer rate and waiting lists indicate that single mothers who are dependent on public assistance will choose to work if a viable alternative, including day care and support, is made available to them. (See pages 59-62.)

COST EFFECTIVE STRATEGIES FOR DECREASING DEPENDENCE ON PUBLIC ASSISTANCE AMONG SINGLE MOTHERS, AND AMELIORATING THE EFFECTS OF THEIR POVERTY

This report cannot provide the information needed to solve the immense problems of poor female headed families. The roots of those problems rest largely in national economic and social patterns that are far beyond the ability of any state agency to address. SRS also recognizes that resources for new or enhanced programs are scarce. But we believe we must begin to make the investment necessary to help reduce future dependence on public assistance, child abuse and neglect, and other problems associated with poverty.

Following are four strategies that could be pursued that have the potential to have a significant impact on the problems of poor single mothers, and that are possible to operate at modest levels with moderate costs. (See pages 63-74.)

- **Provide special employment programs for Aid to Dependent Children mothers of children under six, and provide the day care and other support services needed for these women to successfully participate.** A proposal is presented to select a pilot test site and provide high school equivalency education, vocational education, job search assistance, and day care support to 100 mothers of children three to six years old annually. The 100 mothers would be recruited to volunteer for the program. The cost would be about $110,000.

- **Expand the number of poor pregnant women who receive prenatal care and expand the number of children who receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Included in this strategy should be the expansion of the Medicaid Ribicoff rules to include children from 5 to 21 years old. Three separate proposals are included.**

  - **Prenatal Risk Reduction Classes.** One reason low-income women do not receive adequate prenatal care is that they are not aware of its availability and benefits. SRS's current budget proposals for fiscal year 1987 propose to address this problem by including prenatal risk reduction classes as a reimbursable service in the Medicaid and MediKan programs. These classes will be offered by local health departments. The classes will focus on the need for prenatal care; and the importance of avoiding alcohol, smoking, and other dangers to the pregnancy. In order to encourage clients to take these classes, it may be necessary to add an outreach component to the program, including the use of paraprofessionals as in the EPSDT effort described below.

- **Increase Provider Reimbursement For Prenatal Care.** Another problem that can limit the ability of Medicaid clients to get prenatal care is difficulty in finding providers who accept Medicaid clients. This can be a particular problem in rural areas of the state. Kansas' current reimbursement level of $111 for prenatal care is 56 percent of the regular $200 fee charged to paying patients by physicians at the 75th percentile (i.e. 75 percent charge less than $200 and 25 percent charge more). Low reimbursement is sometimes cited by providers as their reason for limiting the number of Medicaid clients they see. SRS should consider raising the reimbursement rate to 100 percent of the regular fee at the 75th percentile to help ensure the availability of prenatal care providers throughout the state.

- **EPSDT Outreach.** Less than half of eligible Medical Services' clients utilize the effective preventive health care program for children - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). To increase this figure a proposal is presented to select a pilot test site and utilize one or two paraprofessionals to do outreach for the EPSDT program. The outreach would include face-to-face meetings with clients in SRS offices and in clients' homes, and transportation assistance to clients who cannot get EPSDT. This program would cost about $30,000. In addition, central SRS staff would continue their efforts to inform primary care physicians in the Primary Care Network program of their contractual agreement to promote and provide EPSDT services.

- **Expand the number of Ribicoff Children.** As described earlier, it may be possible to add about 450 children to the Medicaid program with little or no cost to the State by including these children over five under the so-called Ribicoff rule. This change would bring some new children into Medicaid, costing the State money. But a larger group currently on the State-funded MediKan program would be shifted to the partially federally-funded Medicaid program, offsetting some or all of the State costs for new clients. A proposal is made to make the regulatory changes needed to implement this expansion of the Ribicoff program.

o **Provide services to Aid to Dependent Children (ADC) clients and other high risk groups designed to prevent child abuse and neglect.** A proposal is presented to select a pilot test site and provide child development and life education classes (including parenting education) to 450 ADC clients, peer support groups to 150 ADC clients, and in-home family services (including parenting education) and support to about 90 clients annually. The cost would be about $80,000.

o **Develop programs in conjunction with the Department of Health and Environment, and the Department of Education, to help prevent unintended pregnancy, and provide services to help teenage mothers avoid dependence on public assistance. These programs should include:**

- **Increased accessibility to Medicaid family planning services.** A proposal is presented to select a pilot test site and work with the local health department to make the one-on-one counseling and

education portion of family planning available in the SRS office on a walk-in basis. The medical portion of family planning (examinations, laboratory, and etcetera) would be done by the regular family planning providers at the regular locations. Outreach workers would be used to encourage the use of these services and make them more accessible. The cost would be $40,000 to $50,000.

- **School-based health clinics that make prenatal care, family planning, and general health services more accessible to low-income teenagers.** Such clinics have been very successful in other states at reducing teenage pregnancy and providing access to primary health care. A proposal is presented to work with other state and local agencies to support development of a school-based health clinic initially in at least one urban high school in Kansas. The clinic would provide access to basic health services and family planning. Approximately 2,000 medical services would be provided annually at a cost of about $160,000. Medicaid would be used to reimburse the clinic for Medicaid covered services they provide to Medicaid eligible students. Other public and private funds would be needed to finance the clinic.

- **Specialized caseworkers for teenage mothers on public assistance to help them access services and plan for their future.** Other states have used specialized caseworkers successfully to provide the additional guidance and support needed by pregnant or parenting teenage public assistance clients to access needed services and make plans to become self supporting. A proposal is presented to select a pilot test site and use one professional and two paraprofessionals to provide case management services to about 300 teenagers at a cost of about $55,000 annually. The case management services would include helping the teenage client to develop a long-term life plan including goals for education and employment; and helping clients to access services needed to achieve those goals, including prenatal care, infant care, family planning, child care to enable the mother to stay in school, employment programs, and others.

TABLE OF CONTENTS

Page

SECTION I: Introduction 1

SECTION II: Female Headed Families Living In Poverty -- The Extent Of The Problem, Factors That Contribute To The Problem, And Some Of The Public Problems Resulting From Poverty In Female Headed Families 3

The Increase In Female Headed Families Has Led To An Increase In The Number Of Children In Poverty 3

Female Headed Families Are Far More Likely To Be In Poverty 4

The Persistently Poor Are Most Likely To Be In Black Or Female Headed Families 5

Some Factors That Contribute To Poverty Among Female Headed Families . . 6

Lack Of Child Support Payments Contribute To Poverty In Female Headed Families 6

The Lack Of Day Care And Other Support Services Limits The Earnings Potential Of Female Headed Families 6

The Increasing Births To Unmarried Teenagers Exacerbate The Problem Of Female Headed Families And Poverty 7

Some Of The Societal Costs Of Female Headed Families In Poverty 11

Female Headed Families, Low Birthweights, And Infant Mortality 12

There Is A Relationship Between Poverty And Female Headed Families, And Abuse/Neglect Of Children, And Foster Care For Children 17

Female Headed Families, Alcohol And Drug Abuse, And Mental Illness . . 18

SECTION III: Data On Kansas Aid To Dependent Children Clients Confirm The Impact Of Teenage Childbirth, The Number Of Children Women Have, Education, And Other Factors On Poverty Among Single Mothers 21

Over Half The ADC Clients Were Mothers As Teenagers 21

Day Care And Transportation Are Cited By Clients As The Problems That Make It Most Difficult To Work 24

Having More Children Is Associated With Being On ADC Longer, Longer Lengths Of Time Since The Last Job Was Held, Having Less Education, And Having More Difficulty Getting Day Care 25

Page

The Women Who Became Mothers As Teenagers Had More Children, Less Education, And Were More Likely To Have Never Worked 25

The Women Who Completed High School Were Somewhat More Likely To Have Recently Worked, While Job Training Was Related To Higher Earnings On Their Last Job 26

Summary Of Key Survey Findings 27

SECTION IV: Kansas Programs That Currently Address The Problems Of Female Headed Families In Poverty 29

Cash Assistance For Single Women With Children 29

The Aid To Dependent Children And Aid To Pregnant Women Programs . . . 29

The General Assistance Program 30

Medical Assistance For Single Women With Children 31

The Number Of Women And Children Served By Medical Assistance 34

The Medical Assistance Program Expended Over Half A Million Dollars For Prenatal Care In Calendar Year 1984 35

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 36

Medical Assistance Family Planning Services 37

Department Of Health And Environment Programs 37

Maternal And Infant Care Programs 38

The Women, Infants, And Children Program 38

The Healthy Start Program 39

The Family Planning Program 39

Child Support Enforcement 39

Recent Changes In The Child Support Program Should Increase Payments . 41

Employment Programs For Single Women With Children 42

The Work Incentive Program (WIN) 42

Most Single Women With Children On ADC Do Not Get WIN Services, Either Because They Are Exempt Or Found Not Job Ready 46

Page

SRS Should Consider Including Mothers Of Young Children In The WIN Program 47

The Need To Extend Medical And Other Services After Employment In Order To Increase Work Incentive And Job Retention 47

The Job Training And Partnership Act Program 48

Programs For Abused And Neglected Children 49

SRS Family Services 49

The Foster Care Program 50

Mothers Who Receive Public Assistance Are A Logical Target Group For Services Designed To Prevent Abuse And Neglect 51

The Youth Center At Beloit 51

Programs At The Beloit Youth Center 51

Alcohol And Drug Abuse Programs 53

Public School Programs Relevant To Single Mothers 54

SECTION V: Initiatives Around The Country That Address The Problems Of Female Headed Families In Poverty **55**

Programs That Focus Services On Teenage Mothers 55

Employment Initiatives 59

SECTION VI: Cost Effective Strategies For Decreasing Dependence On Public Assistance Among Single Mothers, And Ameliorating The Effects Of Their Poverty **63**

Provide Special Employment Programs For Aid To Dependent Children Mothers Of Children Under Six, And Provide Day Care And Other Support Services Needed For These Women To Successfully Participate 64

Background 64

Program Proposal 64

Expand The Number Of Low-Income Pregnant Women Who Receive Prenatal Care, And Expand The Number Of Children Who Receive Early And Periodic Screening, Diagnosis, and Treatment (EPSDT) Services 65

Background 65

Page

Program Proposals 66

Provide Services To Aid To Dependent Children Clients And Other High Risk Groups Designed To Prevent Child Abuse And Neglect 68

Background 68

Program Proposal 68

Develop Programs In Conjunction With The Department Of Health And Environment And The Department Of Education To Help Prevent Unintended Pregnancies, And Provide Services To Help Teenage Mothers Avoid Dependence On Public Assistance 70

Background 70

Program Proposals 70

Other Options 74

APPENDIX I: Footnotes 75

APPENDIX II: Survey Form For Survey Of Kansas Aid To Dependent Children Clients 83

SECTION I

INTRODUCTION

Poverty among single mothers and children has become a critical national concern. As the following table shows, one of every four pre-school children nationally were in poverty in 1983, and that poverty rate is far greater than for older children and adults.

1983 National Poverty Rates

Pre-School Children	25 out of every 100
School-Age Children	21 out of every 100
Elderly Adults	14 out of every 100
Non-Elderly Adults	12 out of every 100

The national poverty rate for all children rose from 14 out of 100 children in 1969, to 16 out of 100 in 1979, and to 22 out of 100 in 1983. According the Congressional Budget Office the severe increase in poverty among children from 1979 to 1983 was likely the result of back-to-back recessions, rapid inflation in 1979 and 1980, and reductions in income maintenance programs.

Comparable Kansas data on the rise in poverty among children does not exist, but the 1980 Census shows that at least 73,000 Kansas children lived in poverty even after counting their public assistance income. Based on the national trend, that figure is probably over 100,000 today.

The alarming increase in child poverty prompted the Kansas Department of Social and Rehabilitation Services to produce this report. This report has several purposes.

- First, to describe the extent of the problem of poverty among single mothers and children.
- Second, to assess some of the factors that contribute to this poverty.
- Third, to assess some of the societal costs of this poverty.
- Fourth, to describe current programs in Kansas and other states that address these problems.
- And Fifth, to propose strategies to reduce this poverty and ameliorate the effects of this poverty.

While SRS recognizes the difficulty of marshaling the resources needed to address this problem, we believe that effort must be made. We have an obligation to do what we can to reverse the rise in child poverty and to decrease welfare dependence. Failing to make this investment in children is extremely shortsighted. If we do nothing, the costs in terms of crime, alcoholism, child abuse and neglect, low birthweight infants, and future dependence on public assistance will be great. An intensified effort to help the State's poor children is in the self-interest of all Kansans.

SECTION II

FEMALE HEADED FAMILIES LIVING IN POVERTY

THE EXTENT OF THE PROBLEM, FACTORS THAT CONTRIBUTE TO THE PROBLEM, AND SOME OF THE PUBLIC PROBLEMS RESULTING FROM POVERTY IN FEMALE HEADED FAMILIES

This section first describes the extent to which female headed families live in poverty. Second, this section describes several factors that contribute to poverty among female headed families, such as low earnings and lack of child support. And third, this section describes some of the costly public problems that result from this poverty, such as poor health, and abuse and neglect of children.

The Increase In Female Headed Families Has Led To An Increase In The Number Of Children In Poverty

The increase in female headed families. Children living in poverty in the United States has increased along with the increase in female headed families. The percent of families headed by single women in the United States has grown dramatically since 1950. In 1950, 2 percent of white families were headed by women, compared to 15 percent in 1982. For blacks the percentage of female headed families rose from 8 percent in 1950 to 47 percent in 1982. 1/ In Kansas, the percentage of families with children under 18 headed by single women rose from 9 percent in 1970 to 13 percent in 1980. In 1980 in Kansas 11 percent of white families, 43 percent of black families, and 16 percent of Hispanic families were headed by single women. 2/ and 3/

Divorced and never-married women contributed to this increase in female headed families. The primary reasons for the growth in female headed families in the United States are increased numbers of divorced women and increased numbers of women with children who have never been married. Concerning divorce, as the following chart shows the percentage of female headed families (in white families) who were divorced rose from 40 percent in 1970 to 57 percent in 1982. The percentage divorced among black female headed families rose from 17 percent to 23 percent. Even more significant was the growth in female headed families where the women were never married, which rose from 3 to 10 percent in white families, and from 18 to 41 percent in black families. 4/

Divorced And Never-Married Single Family Heads (United States)

	1970		1982	
	Black	White	Black	White
Percent Divorced	17%	40%	23%	57%
Percent Never-Married	18%	3%	41%	10%

The increase in births to unmarried mothers. Data on births to unmarried mothers in the United States illustrate the growth in the percent of never-married/female headed households. The number of births to unmarried women as a percent of all births increased from 4.0 percent in 1950 to 18.9 percent in 1981. The big increases in this percentage came between 1960 and

1970 (5.3 to 10.7 percent) and between 1970 and 1980 (10.7 percent to 18.4 percent). 5/

Births To Unmarried Women As A Percentage Of All Births (United States)

Year	Percentage
1950	4.0%
1960	5.3%
1970	10.7%
1980	18.4%
1981	18.9%

The dramatic increase in children living in female headed families. As a logical consequence of the increased number of female headed families, the percentage of children living with one parent nationally increased from 9 percent in 1960 to 19 percent in 1978, and the figure is projected to be 25 percent (or one out of every four children) by 1990. 6/

Female Headed Families Are Far More Likely To Be In Poverty

The increase in female headed households has a direct effect on poverty rates among children. Income for these families is lower as a result of having a female head. In 1982, white married couples nationally had a medium income of $26,443 while white female headed families had a medium income of $13,498. In the same year black married couples had a medium income of $20,586, while black female headed families had a medium income of $7,458. 7/ In Kansas in 1980, the median income for white female headed families was 51 percent of income for white families headed by married couples. Black female headed families made 37 percent of the income for black families headed by married couples. And Hispanic female headed families made 44 percent of the income for Hispanic families headed by married couples.

The increase in female headed families and the higher poverty rate among female headed families have led to high poverty rates among children. Partly as a result of more female headed families, the poverty rate nationally among school-age children rose from under 14 percent in 1969 to 21 percent in 1983. 8/ The percentage of children under age six in 1983 reached 25 percent or one out of every four children. 9/ In contrast a comparatively low 14 percent of the elderly were in poverty in 1983. 10/ As evidence of the relationship of female headed families and the increase in children in poverty, in 1981 19 percent of children under 18 lived in poverty, while the poverty rate for children living in female headed households was 52 percent. 11/

Like the national figures, 1980 Kansas Census data show female headed families in Kansas are far more likely to be in poverty than other families. In 1980, there were 331,000 families with children in Kansas. Of those, 32,000 or about 10 percent lived in poverty. (These poor families included 73,000 children living in poverty in Kansas.) In contrast 33.7 percent of female headed families with children lived in poverty. Looking at the data another way, just over one in ten of all families with children in Kansas were female headed, yet almost half of families with children living in poverty were female headed. 12/

To compare Kansas, national, and regional figures, a slightly different measure than the percent of families with children in poverty was used. The following table shows poverty rates for all families, rather than the poverty rate only for families with children. 13/

Percentage Of Families And Female Headed Families In Poverty - 1980 Census

	% Of All Families In Poverty	% of All Female Headed Families In Poverty
Iowa	6.9%	24.1%
Kansas	7.6%	26.4%
Colorado	7.6%	27.0%
Nebraska	7.7%	23.8%
Missouri	9.2%	25.4%
Oklahoma	10.4%	31.7%
United States	9.6%	30.4%

The table shows female headed families are far more likely to be in poverty than other families in every state in the region.

The Persistently Poor Are Most Likely To Be In Black Or Female Headed Families

A unique study done by the University of Michigan included data collected on the heads of over 5,000 families, representing a cross section of the nation in all economic categories. The same individuals were interviewed every year from 1968 to 1978, allowing researchers to assess for the first time whether or not the seemingly static group of poor people were comprised primarily of the same people who remained in poverty year after year. 14/

In this study half of those in poverty in one year were not in poverty the next, and almost one quarter of all families were in poverty at least once in the ten year period. The Study found the poverty population is not static. Only a little over half of the persons in the Study living in poverty in one year were poor the next year. 15/ The Study found only three percent of the study's population was persistently poor during the 1969 to 1978 period, meaning they were poor in at least eight of the ten years. The Study also found 24 percent of the study's population experienced at least one year of poverty during the ten-year period, indicating that poverty is more widespread among the entire population than is commonly thought. That is, nearly one in four American families in the study were in poverty at some point in the ten years. 16/

Black and female headed families in the study were most likely to be persistently poor. The study also assessed the characteristics of the persistently poor and found "the persistently poor are heavily concentrated in two overlapping groups: black households and female headed households." 17/ More specifically, only two out of five families in the study were female headed in 1978, yet nearly two-thirds of the persistently poor in the study lived in female headed families. 18/ As a result, one of the Study's conclusions is that "one possible long-range solution to preventing long-term poverty

before it occurs is to prevent unwanted pregnancies ...." 19/ This concept will be touched on repeatedly in this report.

Some Factors That Contribute To Poverty Among Female Headed Families

The causes of poverty among female headed families are many and a full discussion of the issues is beyond the scope of this study. This section discusses several of the key factors that contribute to poverty among female headed families.

Clearly one factor in poverty in female headed families is that men earn more than women. A National Governor's Association study reported that in 1980 women working full-time year round earned a median income of $11,590 or 59 percent of what men earn ($19,172). Including men and women who work part-time, median income for women ($4,919) is only 39 percent of median income for men ($12,592). 20/

The differences in earnings for men and women are important factors to keep in mind as long range solutions to poverty in female headed families, but solutions to those problems are out of the reach of a social services agency like SRS. The next several sections discuss issues that are within the ability of SRS to influence in the short-term: child support, day care, and adolescent pregnancy.

Lack Of Child Support Payments Contribute To Poverty In Female Headed Families

Single women and their children are far more likely to be in poverty than married women and their children. One reason is that child support from absent fathers is frequently nonexistent. Nationally, 59 percent of single women with children were awarded child support payments, based on a 1983 United States Census Bureau study. But only about 47 percent of those women receive the full payment. 21/

As a result of so many women not receiving child support due to them and the growing number of female headed families, increasing the percentage of women receiving child support is considered by the University of Wisconsin Institute for Research on Poverty and other national experts as a primary means to reduce poverty among female headed families. As a public policy option this approach has the advantage of not relying on increased expenditures for public assistance. Later sections of this report discuss recent changes to increase child support collections in Kansas and even greater changes being tested in other states.

The Lack Of Day Care And Other Support Services Limits The Earnings Potential Of Female Headed Families

The availability of day care, and other support services like transportation, have not kept up with the increase in female headed families. In fact the number of children receiving day care funded by SRS each month declined from 5,298 in fiscal year 1980 to 2,481 in fiscal year 1985. Looking at the data from a national perspective and including non-poor families, there were only six million day care spaces in 1981 for the 22 million children under age 13 whose mothers worked. 22/

For single women with children working their way out of poverty may be made impossible by the lack of day care, transportation, medical care, and other support services. According to the Children's Defense Fund between 17 and 20 percent of all unemployed women are without work because they do not have access to affordable day care. 23/ A survey of Kansas Aid to Dependent Children clients done by SRS reinforces the importance of day care to low-income women seeking work.

Having young children does not negate the possibility of leaving public assistance by working, but having more children makes leaving by working less likely. In 1983 two Harvard Researchers analyzed data that included 676 female heads of families who had received public assistance between 1968 and 1979. 24/ Two of their findings are particularly relevant to this concept that support services can enable women to escape public assistance.

One of the key findings in this study was that of those women who left public assistance by earning income (as opposed to getting married or having children leave the family), 67 percent were mothers of children under six. 25/ This finding is significant in that women with young children have generally been left out of employment programs. This study indicates these younger women have the desire and capacity to work. But clearly day care services will need to be expanded if women with young children are added to employment programs.

Another significant finding of the Harvard study was that women with just one child are twice as likely to leave public assistance through earnings as are the women who had three children. The study's authors concluded, "It may well be that young mothers who avoid having additional children are likely to have shorter stays and are much more likely to earn their way off welfare." 26/ As a result, programs that make family planning available to public assistance recipients, and counseling to encourage the use of those services, may yield significant reductions in welfare dependency.

The Increasing Births To Unmarried Teenagers Exacerbate The Problem Of Female Headed Families And Poverty

A previous section pointed out that there has been an increase in the percent of births to unmarried women. Of particular concern are increases in births to unmarried teenage women, because single teenage mothers face even greater problems than single mothers in general. Teenage mothers are less likely to complete their education, are more likely to be unemployed, and are more likely to be in poverty and on public assistance. They also have more children, which increases their poverty because they have more to feed and clothe.

Birth rates for teenagers have declined. Since 1955 overall birth rates to teenagers have declined. Nationally, birth rates per 1,000 for white women age 15 to 19 have declined steadily from 79 in 1955 to 45 births per 1,000 in 1979. Among nonwhite teenagers age 15 to 19 there was a similar decline from 168 births per 1,000 in 1955 to 100 in 1979. 27/

But births to unmarried teenagers have increased. Despite the general decline in births to teenagers, the number of births per 1,000 to **unmarried** white teenagers increased steadily during the same 1955 to 1979 period from 6 per 1,000 to 15 per 1,000, while the increase for nonwhite teenagers was from

78 to 87 per 1,000. These data show the largest increase in births to unmarried teenagers were among white teenagers. 28/

Births To Unmarried Teenagers Per 1,000 Teenagers (United States)

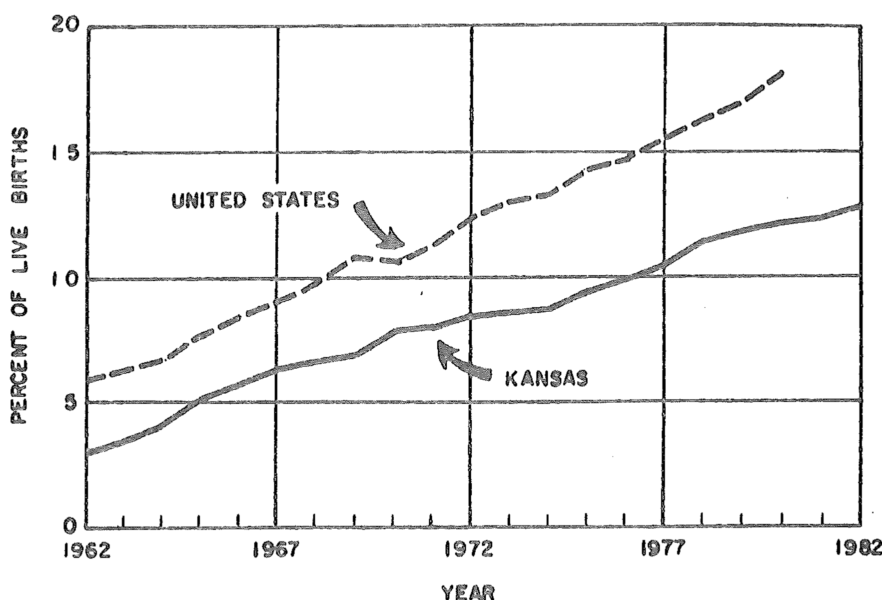
1955		1979	
Non-White	White	Non-White	White
78	6	87	15

The percentage of teenage births to unmarried teenagers has increased. As another way of looking at these data, the number of births to unmarried teenagers age 15 to 19 as a percentage of all teenage births increased for white teenagers from 8 percent in 1960 to 34 percent in 1979. For nonwhite teenagers the percentage rose from 48 to 87 percent in the same period. 29/ In 1982 births to adolescents accounted for 14 percent of all first births. And 51 percent of the 525,000 teenage births nationwide were to unmarried teenagers. 30/

In sum, a large and growing proportion of infants are being born to single teenage mothers. And as stated earlier, teenage motherhood makes economic success far less likely.

Kansas Births To Unmarried Mothers Have Also Increased, But Kansas' Percentage Of Births To Unwed Mothers Is Slightly Lower Than The National Average. Births to unmarried mothers in Kansas have increased from about three percent of all births in 1962 to about 13 percent in 1982. The following chart shows the increase has paralleled the national increase, but Kansas' percentage has been lower throughout the period.

OUT-OF-WEDLOCK BIRTH RATIOS
KANSAS AND THE UNITED STATES, 1962-1982



Source: Kansas Department of Health and Environment

As occurred nationally, the percentage of total births that were to teenagers in Kansas was declining (from 20 percent in 1972 to 13 percent in 1982), while the percent of births to unmarried mothers was increasing. By 1982, 39.4 percent of all births to women under 20 in Kansas were to unmarried teenagers. 31/ And out of all births to unmarried women, 40.8 percent were to women under 20. Kansas' 39.4 percent of all teenage births being to unmarried teenagers is the ninth lowest percentage of all 50 states, and is the second lowest in the region. 32/

Percentage Of Births To Women Under Age 20 Who Are Unmarried

Oklahoma	32.3%
Kansas	39.4%
Colorado	44.5%
Iowa	44.7%
Nebraska	48.7%
Missouri	50.2%

The following sections describe how the increase in births to unmarried teenagers exacerbates the problem of poverty among single headed families.

Teenage Mothers Are Less Likely To Complete Their Education And More Likely To Be Unemployed. Education is a factor in future earnings and poverty. One study that included a large national sample showed women with a high school diploma are about half as likely to live in an Aid to Dependent Children family as women without a high school diploma. 33/ In Kansas in 1980, almost half of young mothers age 15 to 24 with a high school education were in poverty, while three quarters of young mothers without a high school education were in poverty. 34/

Pregnancy reduces the likelihood of completing high school. Thus, completing high school is an important factor in future earnings, yet not surprisingly pregnancy increases the likelihood of not finishing school. For example, one national study found pregnancy, marriage, and dissatisfaction with school are the three reasons most often cited by females for dropping out of school. 35/

The following table shows the results of a national study that indicate between 1968 and 1979 the percentage of pregnant teenagers remaining in and returning to school is growing, but the percentages are still discouragingly low. 36/

Percent Of Women, Age 14-22, Enrolled In High School Five Months Before Delivery And Five Months After Delivery

	Five Months Before		Five Months After	
	1968	1979	1968	1979
White	17.2%	36.5%	4.9%	16.4%
Black	43.2%	59.5%	20.3%	35.8%

Teenage mothers who stay in school have fewer children. One reason for encouraging young mothers to stay in school is that teenage mothers who drop out are more likely to have more children. One study showed 40 percent of

mothers who quit high school after the first childbirth had at least two more pregnancies. In contrast only 25 percent of mothers who completed school had at least two more children. 37/

In addition to the effects on education, having children as a teenager reduces future employment. A study using census data showed that in 1979 51.3 percent of young women with children were in the labor force (looking for work), while 36.5 percent of those were unemployed. Young women without children were more likely to be in the labor force (83.8 percent), and less likely to be unemployed (14.1 percent). 38/

The number of children a teenage mother eventually has is a major factor in future employment. In a study that tracked teenage mothers from 1966 to 1972, 43 percent of the young mothers with only one child had been employed steadily in the last two years of the study, as compared to only 10 percent of the mothers with more than one child. 39/ One likely explanation of this is the increasing difficulty of finding affordable child care as the number of children increases.

In sum, becoming pregnant reduces the likelihood of finishing high school and becoming employed. For young women who do become pregnant, staying in school increases their chances at economic success and decreases the likelihood of their having more children.

Teenage Mothers Are More Likely To Live In Poverty And Be On Public Assistance, Partly Because They Have Larger Families And Are Less Likely To Be Married. Considerable research has shown an association between early motherhood and later poverty. But few studies have considered whether or not other characteristics of these young mothers may have been the key factor. In other words, maybe these mothers would have been in poverty even if they had delayed childbirth.

A 1978 Urban Institute study attempted to assess the effects of early childbirth on education, employment, income and other factors for women with similar socioeconomic characteristics. Using extensive data following the same people over several years, this study showed early childbirth is in itself an important factor in future poverty. 40/

One of the Urban Institute study's most significant findings was that women who were teenage childbearers had larger families. Women in the study who were age 17 or younger at first birth had over five children each. Women who were at least age 20 at first childbirth had closer to three children. 41/ Another study showed mothers who had their first child as teenagers had an average one more child than women who had their first child after their teens. 42/

The Urban Institute Study concluded early childbearers end up earning less total income and dividing that income among larger families than later childbearers. Thus, for women in the study who had children at age 18 or younger, the probability that the woman's family will be in poverty is reduced by 2.5 percentage points for each year childbirth is delayed. 43/ Other studies show women with larger families are more likely to receive welfare and stay on welfare than women with smaller families who are similar in other ways. 44/

Another reason teenage mothers are more likely to be in poverty is that they are more likely than other mothers to be unmarried. In Kansas 40.8 percent of all out-of-wedlock births were to teenage mothers.

Teenage Childbirth And Public Sector Costs. As mentioned above women who were teenage mothers are overrepresented among public assistance recipients. For example, a 1975 study looked at women under 30 who bore their first child in 1970. They found 71 percent of these women who were receiving Aid to Dependent Children in 1975 bore their first child as teenagers, while only 37 percent of all these women (whether or not they received assistance) bore their first child as teenagers. 45/ Later studies of smaller geographic areas found similar results. Also, the 1975 national study estimated 56 percent of the Aid to Dependent Children budget went to families of women who were teenage mothers. Not surprisingly, studies show that since teenage mothers have larger families, their average benefits are higher than those public assistance recipients who had their first child later. 46/

According to a 1982 Urban Institute Study, total public assistance benefits paid to families in which the mother was a teenager at first birth were $8.6 billion in 1975 (public assistance here includes Aid to Dependent Children, Medicaid, and Food Stamps). 47/ Of course, this total amount would not be saved by preventing teenage pregnancies since some percentage of these families would require public assistance even if childbirth were delayed.

Reducing teenage pregnancy would reduce public assistance costs significantly. To estimate the amount of public assistance that would be saved by reducing teenage pregnancy, the Urban Institute used knowledge about the effects of teenage pregnancy on education, employment, future childbearing, and other factors, to estimate the changes in public assistance that would occur under varying scenarios about changes in teenage births. They determined, for example, that cutting teenage birth rates by half would reduce Aid to Dependent Children costs by 25 percent or 9.2 billion in 1990. 48/ In Kansas, this reduction in costs would be over $20 million.

These data show clearly that the existence of high teenage birth rates have a significant effect on the need for public assistance and public assistance costs. By reducing teenage birth rates, it is therefore possible to reduce the size of a group of our population that is particularly vulnerable to poverty, particularly long-term poverty.

Some Of The Societal Costs Of Female Headed Families In Poverty

The poverty experienced by female headed families is in itself a serious problem that deserves public attention. But equally as important as the state of being in poverty are the problems spawned by that poverty. This study does not attempt to address the relationship of poverty to all these issues, but focuses on several problems related to poverty, reliance on public assistance, and health.

Poverty and general ill health are related. According to a recent report of the federal Public Health Service, disadvantaged people become ill because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health care. 49/ When poor people become ill the cost to society is great. Kansas will expend $233.1 million in fiscal year 1986 to provide

medical care to poor Kansans (Medicaid and MediKan). The following discussion focuses on several specific health problems that are related to poverty: infant mortality and low birthweights, abuse and neglect of children, foster care, mental illness, and alcohol and drug abuse. The relationship of adolescent pregnancy to some of these problems is also discussed.

Female Headed Families, Low Birthweights, And Infant Mortality

Infant mortality and low birthweights are considered key indicators of public health. Reducing the incidence of these health-related problems is a primary goal in improving the health status of impoverished female headed families.

Trends In Infant Mortality And Low Birthweights. Infant mortality has steadily declined in the United States from 24.7 per 1,000 live births in 1965 50/, to 13.1 in 1980 51/, and to 10.9 in 1983. 52/ Still 18 other countries have lower infant mortality rates. The United States' ranking has fallen from 7th lowest in infant mortality in the 1950s to 18th lowest in infant mortality in 1983. The infant mortality rate is now one of the highest in the developed world. In the United States, more people die in the first year of life than during any year until age 65. 53/

According to the National Institute of Medicine, most of the declines in infant mortality are due to increased survival among low birthweight infants made possible by improved neonatal intensive care units. Moderate declines in low birthweight itself have played a minor role in the decline in infant mortality. The Institute of Medicine concluded further improvements in infant mortality will require actions to reduce the incidence of low birthweight and pre-term infants. 54/

In Kansas the infant mortality rate is lower overall than the national average (10.1 per 1,000 births compared to 10.9 nationally), but the Kansas rate has not fallen in recent years as has the national average. The Kansas infant mortality rate was 10.1 per 1,000 births in 1980 and again 10.1 in 1983, while the national rate fell from 13.1 to 10.9 in those years. Also Kansas' ranking in terms of infant mortality fell in comparison to other states. Kansas had the fourth lowest infant mortality rate in 1973, but in 1983 Kansas was tied with Massachusetts with the 14th lowest rate. 55/

As mentioned above, while infant mortality in the United States was declining rapidly, the incidence of low birthweight infants nationally declined minimally between about 76 and 68 births per 1,000 from 1971 to 1981. 56/ Low birthweight is defined as less than 5.5 pounds. As with infant mortality, the overall incidence of low birthweight infants in Kansas (62 per thousand in 1982) is slightly lower overall than the national rate (68 per 1,000 in 1981).

Low Birthweights Are Higher In Kansas Than The National Average When Broken Out Separately For Blacks and Whites. The statistic in the previous paragraph that stated Kansas has a smaller percentage overall of low birthweight infants than the national average provides only part of the story. The following table shows a clearer picture.

Low Birthweights Per 1,000 By Race
1982

	Kansas	**United States** 57/
White (a)	61	56
Black	140	124
Total Population	62	68

(a) Includes Hispanic population.

The table shows white women have more low birthweight infants in Kansas (61 per 1,000) than the national average (56 per 1,000). Also, black Kansas women have more low birthweight infants (140 per 1,000) than the national average (124 per 1,000). The reason Kansas' total rate (62) is less than the national rate (68) is that Kansas has a much smaller black population (5.3 percent) than in the national population (11.7 percent). 58/

Thus, within the two separate demographic groups, black and white, Kansas has higher rates of low birthweight infants than the national average. Since the incidence of low birthweight infants can be reduced through proper nutrition, medical care, and other precautions, reducing low birthweights in Kansas is an important public health concern.

Problems Associated With Low Birthweight, And Women Most Likely To Have Low Birthweight Infants. Low birthweight infants are a prime factor in infant mortality. The national Institute of Medicine concluded two-thirds of infant deaths during the first 28 days of life occur among low birthweight infants. Also, low birthweight infants are five times more likely than normal birth weight infants to die later in the first year. For low birthweight infants who live, they are three times more likely to have some type of neurological handicap (including mental retardation, cerebral palsy, and seizure disorders). 59/ Two recent studies concluded the 20 percent of low birthweight infants who have handicaps will require over $120,000 in special education and other special costs for the life of the child. 60/ Low birthweight infants are also more likely to have conditions requiring immediate treatment such as respiratory infections.

Not surprisingly the immediate costs of caring for low birthweight infants is much greater than normal birthweight infants. According to the Kansas Department of Health and Environment, there were 1,169 infants, primarily low birthweight infants, who required Level III hospital intensive care in Kansas in 1982. The 1,050 surviving infants had an average hospital stay of 20 days at an approximate cost of $1,000 per day. Further, the Institute of Medicine study found that nationally 19 percent of all low birthweight infants are rehospitalized more than once during the first year of life for an average 12.5 days. The comparable figures for normal birthweight infants are 8.7 percent rehospitalized for eight days. 61/

Research shows that certain groups of women are more likely than others to have low birthweight infants. Unmarried women, minority women, teenagers, and women who smoke, all have an increased likelihood of having low birthweight infants. In 1980, 12 percent of births to unmarried women were low birthweight, compared to 6 percent for married women. These differences

persist even among women of the same age and race. Teenage mothers also are more likely to have low birthweight infants because they are more likely to be unmarried, black, have low socioeconomic status, and are less likely to receive adequate prenatal care. 62/ In Kansas in 1982, 8.3 percent of births to women 15 to 19 were low birthweight, compared to 6.2 percent for all births.

Preventing Low Birthweights Through Prenatal Care. One reason teenage mothers are more likely to have low birthweight infants is they are less likely to receive adequate prenatal care. According to the National Center for Health Statistics, in 1981 12 percent of 15 to 17 year old mothers, compared with six percent of 20 to 24 year old mothers, did not receive prenatal care until the last trimester or received no care at all. 63/

Most studies of prenatal care conclude prenatal care is effective in reducing the chance of low birthweight, particularly among high risk women, such as teenagers. Some studies indicate programs that have the greatest effect are programs that offered combinations of education, psychosocial and nutrition services, and clinical activities such as medical screening.

One noteworthy project is the California Obstetrical Access Pilot Project. The project provided to low-income women eight or more medical prenatal visits, nutritional and psychosocial assessments, 16 hours of childbirth classes, prenatal vitamins, and over 30 diagnostic tests. The recipients had only a 4.7 percent incidence of low birthweight infants compared to 7.1 percent in a matched comparison group of women who received only routine prenatal visits. 64/ In this study as in others it is not clear if the classes and other support services caused the decrease in low birthweight or if the increased number of prenatal visits (encouraged by the classes) caused the decrease in low birth- weights. After reviewing these and other studies, the Institute of Medicine concluded over $3 in medical care could be saved for every $1 spent on prenatal care. 65/

A 1984 Kansas study mirrors the national findings on prenatal care. Data on 120,212 births during 1980, 1981, and 1982 were examined for the study. 66/ The study found 5 percent of women with adequate prenatal care had low birthweight infants compared to 11 for women with marginal care, and 12 percent for women with inadequate care. 67/ The adequacy of care was defined based on the number of prenatal visits and the time during the pregnancy of the first prenatal visit.

Adequacy Of Prenatal Care And Incidence Of Low Birthweight Infants In Kansas

	Adequate Care	Marginal Care	Inadequate Care
Percent Low Birthweight Infants	5%	11%	12%

The Kansas study also found teenagers age 10 to 14 were less likely to receive adequate prenatal care (51 percent) than women 15 to 19 (70 percent), or women 20 to 24 (82 percent). 68/

Kansas Medicaid Clients Have A Higher Incidence Of Low Birthweight Infants Than Other Kansans, And Increased Prenatal Care Appears To Decrease Low Birthweights Among Kansas Medicaid Clients' Infants. To gain information about Kansas Medicaid clients level of low birthweight and prenatal care, SRS and the Department of Health and Environment worked together to produce a computer tape with this information. SRS provided data on all Medicaid clients under one year old in calendar year 1984. The Department of Health and Environment then provided data on those Medicaid clients for whom it could match data from birth certificates on birthweight, prenatal care, and other information. The analysis of these data follows.

During calendar year 1984 there were 7,919 Medicaid clients under one year old. The Department of Health and Environment was able to provide birth certificate data on 5,753 or 72.6 percent of these clients. The following table shows the percentage of low birthweight infants among this Medicaid population compared to all Kansans.

Percentage Of Low Birthweight Infants
All Kansans And Medicaid Clients (1984)

	Black	**White**	**Total**
All Kansans	12.5%	5.6%(a)	6.1%
Medicaid Clients	14.4%	9.2%(a)	9.6%

(a) Includes Hispanic population.

The table indicates that overall Medicaid clients have a significantly higher incidence of low birthweights than all Kansans (9.6 percent compared to 6.1 percent). One reason for this is that there are more black clients in the Medicaid data (23.9 percent) than there are blacks in the general Kansas population (5.3 percent), and blacks have a higher incidence of low birthweight infants.

The table also shows white Medicaid clients have a higher incidence of low birthweight infants (9.2 percent) than in the general white Kansas population (5.6 percent). Also, black Medicaid clients have a higher incidence of low birthweights (14.4 percent) than the general black Kansas population (12.5 percent).

As in the general population teenage Medicaid mothers are more likely to have low birthweight infants than other mothers. Among the 5,753 Medicaid mothers in this study, the 1,715 teenage mothers had a low birthweight incidence of 10.7 percent. The remaining 4,083 mothers had a low birthweight incidence of 9.1 percent.

Concerning the Medicaid clients usage of prenatal care, the data show 32.1 percent of all the Medicaid clients had less than nine prenatal visits, 19.0 percent had less than seven visits, and 6.8 percent had less than four visits. The Department of Health and Environment considers nine prenatal visits beginning in the first trimester as minimally adequate prenatal care. (The nine visit level is based on a gestation of 36 weeks. Longer gestations require more visits and the optimal number of visits in a normal pregnancy is 11 to 15.) Of the Medicaid clients, 27.2 percent did not begin prenatal care until

the second trimester, and 7.0 percent did not begin prenatal care until the final trimester.

In order to assess the effect of prenatal care on low birthweight, we removed from the data base clients who had illnesses such as diabetes, syphilis, or uterine bleeding during the pregnancy. Leaving these clients out provides a clearer picture of the effects of prenatal care. Clients who smoked or were alcoholics were left in since prenatal care can influence these behaviors. Interestingly the overall rate of low birthweights was significantly lower (6.1 percent low birthweight) among the 4,056 Medicaid clients without illnesses or complications than the rate among the 5,753 total Medicaid clients (9.6 percent low birthweight). The following tables show that among the 4,056 clients without illnesses or complications, the incidence of low birthweight is significantly lower for clients who had more prenatal visits and began prenatal care in the first trimester.

Prenatal Care And Low Birthweight Infants For Medicaid Clients (For Mothers With No Concurrent Illnesses or Complications)

Number of Prenatal Visits	Percentage of Low Birthweight Infants
0 to 3	14.7%
4 to 6	13.0%
7 to 9	6.3%
10 to 12	4.3%
13 to 15	2.8%
16 or more	1.9%

Trimester Care Began	Percentage of Low Birthweight Infants
First	6.0%
Second	6.3%
Third	8.2%

The following chart, which includes clients with and without concurrent illnesses and complications, shows an even more startling pattern of fewer low birthweight infants as prenatal care visits increase.

Prenatal Care And Low Birthweight Infants For Medicaid Clients (For All Mothers, Including Those With Concurrent Illnesses Or Complications)

Number of Prenatal Visits	Percentage of Low Birthweight Infants
0 to 3	20.5%
4 to 6	19.7%
7 to 9	10.2%
10 to 12	6.6%
13 to 15	3.4%
16 or more	6.8%

Not surprisingly the Medicaid mothers who were teenagers were less likely to receive prenatal care. Of the teenage clients, 36.0 percent had fewer than nine prenatal visits, while 30.5 percent of older clients had fewer than nine prenatal care visits. (These data are for all clients, with and without complications or concurrent illnesses.) This finding mirrors other Kansas and national studies discussed earlier that show teenage mothers are less likely to receive adequate prenatal care.

Prenatal Care Utilization By Age

	Teenage Clients	Older Clients
Percent With Fewer Than Nine Prenatal Visits	36.0%	30.5%

In sum, the data show Medicaid clients are far more likely to have low birthweight infants than the general Kansas population, and Medicaid clients who have inadequate prenatal care are far more likely to have low birthweight infants. The evidence is clear that programs designed to ensure Medicaid clients receive adequate prenatal care (particularly if that care includes counseling on preventive health care) will reduce the incidence of low birthweight infants. Programs aimed at teenage mothers would be particularly effective since they are most likely to not receive adequate prenatal care and have low birthweight infants. As mentioned earlier in this study, the National Institute of Medicine concluded that $3 is saved in the cost of caring for low birthweight infants for every $1 invested in prenatal care.

There Is A Relationship Between Poverty And Female Headed Families, And Abuse/Neglect Of Children, And Foster Care For Children

One of the societal costs of poverty is the relationship of poverty to abuse and neglect of children. While clearly it is in our interest to try and prevent abuse and neglect on the merits of prevention alone, the absence of effective prevention also costs money. Abused and neglected children may end up being placed in foster care (in the custody of SRS) at a significant cost to the State. Foster Care in Kansas can cost from about $5 per day for family foster care for young children to over $100 per day for specialized group homes.

National studies show that abuse and neglect occurs most frequently among families that have low-income. 69/ One national study found abuse and neglect was much greater among families with incomes under $7,000. 70/ In Kansas, in the first half of fiscal year 1985, 35 percent of all families that had reports of abuse or neglect on them were public assistance recipients. Of all families receiving SRS services designed to prevent the need for foster care, in fiscal year 1984, 56.7 percent were public assistance recipients.

Public Assistance Clients And Abuse and Neglect

1985 Percent Of Abuse/Neglect Reports That Were On Public Assistance Clients . .	35%
1984 Percent Of Family Services For Public Assistance Clients	57%

Based on these data, we can conclude that poverty appears to be a factor in abuse and neglect cases, and certainly programs to limit abuse and neglect could logically be focused on poor families. And since female headed families are more likely to be poor, female headed families should also be a target group for such services.

Social problems such as abuse and neglect not only have a myriad of causes, but they also frequently have a myriad of consequences. We found one piece of startling evidence of the spiraling nature of these problems. The Youth Center at Beloit is a facility for juvenile delinquent females. The Youth Center's records show 75 percent of the Center's 76 residents in June 1985 were confirmed or suspected victims of abuse or neglect. Staff at the Center indicated most of these adolescents come from low-income families. The costs to society of the abuse and neglect of these children is high. Not only have these victims of abuse and neglect committed criminal acts, they are also regarded as a high risk group for becoming teenage mothers and repeating a cycle of poverty and potential abuse.

Concerning foster care and its relationship to poverty among single mothers, in January of 1985 about 40 percent of all children in SRS custody were from families that either were eligible for Aid to Dependent Children or would have been eligible if they had applied. Thus, a large percentage of foster children come from poor female headed families. In order to further assess the relationship between foster care and female headed families, we collected data for each Kansas county on the percentage of families with children under age 18 that were female headed, and the number of children in SRS custody per 1,000 population. * The analysis showed there is a statistical relationship between female headed families and the number of children placed in foster care. 71/ That is, counties with a higher proportion of female headed families are likely to have a higher incidence of foster care placements.

Female Headed Families, Alcohol And Drug Abuse, And Mental Illness

Alcohol and drug abuse among women is linked to many other problems addressed by SRS programs. For example, alcohol and drug abuse is linked to low birthweights, which in turn contributes to higher Medicaid costs. A recent study concluded that among the types of women most likely to abuse alcohol are never-married women, divorced or separated women, and unemployed women seeking work. 72/ Thus, in developing comprehensive programs to address the problems of female headed families in poverty, alcohol and drug abuse programs must be included.

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* We found there is a statistical correlation ($r=.505$) between the percentage of female headed families and the number of foster care children per 1,000 in Kansas counties. More specifically, this statistic tells us that about 25 percent ($r^2=.25$) of the variation between counties in the number of foster care children per 1,000 can be accounted for by variations in the percentage of female headed families in these counties.

The final problem related to female headed families and poverty in this study is mental health. One study based on rates of utilizing mental health services, and several national mental health surveys, concluded the greatest increases in depression in recent years are among young, poor, female heads of families; and young married mothers working in low-level jobs. 73/ Not only does this finding reveal another societal cost of women in poverty, but the resulting depression may make efforts to help women leave poverty through work more difficult.

SECTION III

DATA ON KANSAS AID TO DEPENDENT CHILDREN CLIENTS CONFIRM THE IMPACT OF TEENAGE CHILDBIRTH, THE NUMBER OF CHILDREN WOMEN HAVE, EDUCATION, AND OTHER FACTORS ON POVERTY AMONG SINGLE MOTHERS

The program designed specifically to provide financial assistance to single mothers with children in Kansas is the Aid to Dependent Children/Regular program. There is also an Aid to Dependent Children/Unemployed Parent program to help certain types of two-parent families. The previous pages have discussed the relationships of teenage childbirth, the number of children, education, and other factors as contributors to poverty among single women with children. In order to assess the characteristics of the Aid To Dependent Children (ADC) clients and the relationships of the above mentioned factors to their poverty, SRS conducted a survey of ADC/Regular clients.

In May 1985, there were 17,984 open ADC/Regular cases. Survey forms were mailed to 773 of those clients and 292 usable surveys were returned. * Of the 292 usable surveys returned, 60 of those were grandmothers who were heads of families that generally include their children and grandchildren. Another ten surveys were from single men who were heads of families. Only the remaining 222 surveys filled out by single female heads of families were included in the analysis.

In order to ensure the validity of the survey, beyond taking a large enough sample, a pretest the survey was conducted to ensure clients correctly understood the questions. Sixteen draft surveys were filled out by clients at the Topeka Area Office, and 14 of those clients were interviewed to assess their comprehension of the questions. Wording changes were made in several questions as a result of the pretest. In sum, the survey of ADC clients was based on a pretested form and a statistically valid survey.

Over Half The ADC Clients Were Mothers As Teenagers

The following chart shows 52.3 percent of the surveyed ADC clients had their first child before they were 20.

Age Of Mother At Birth Of First Child

Age	Percent	
14 or younger	3.2%	52.3% (14 to 19)
15 to 17	23.0%	
18 to 19	26.1%	
20 to 24	35.1%	
25 to 30	9.9%	
Over 30	1.8%	
No Answer	.9%	

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* This sample of 292 is statistically valid at the 90 percent confidence level, plus or minus five percent. That means that nine out of ten samples of this size will yield data that approximate the characteristics of the entire 17,984 clients within plus or minus five percent.

Women who were teenagers when their first child was born are over-represented in the ADC population (52.3 percent of ADC population). In comparison, a 1982 Census Bureau study found that between 1977 and 1982 28.8 percent of women who had their first children in those years were teenagers when their first child was born. 74/

Although the survey does not tell us the marital status of these women at the time of their first child's birth, it does tell us that 28.4 percent were never married. Another 39.6 percent were divorced at the time of the survey, 20.3 percent were separated, and .9 percent were widowed. The remaining 10.8 percent were married, but it is likely most of those were not living with their spouse.

Marital Status Of Respondents

Never Married	28.4%
Divorced	39.6%
Separated	20.3%
Widowed	.9%
Married	10.8%

Other basic descriptive data about the women in the survey are summarized below:

- **Time Since Last Job** - Of the total in the survey, 10.8 percent of the surveyed women had never worked, while 39.6 percent had not worked in the last two years. Another 7.2 percent of the women were currently working and 42.4 percent had worked in the last two years.

Time Since Last Job

Never Worked	10.8%
Not Worked in Last Two Years	39.6%
Worked Sometime in the Last Two Years	42.4%
Currently Working	7.2%

- **Salary On Last Job** - Of the women in the survey who had ever worked, 20.5 percent earned less than $3 per hour, 58.5 percent earned $3 to $4 per hour, 16.9 percent earned $4 to $6 per hour, and 4.1 percent earned $6 to $10 per hour. In sum, the vast majority of these women (79 percent) earned less than $4 per hour.

Earnings On Last Job For Women Who Had Ever Worked

Less Than $3	20.5%
$3 - $4	58.5%
$4 - $6	16.9%
$6 - $10	4.1%

A woman earning $3 per hour will earn about $500 a month before taxes. At $4 per hour the total is $688 per month before taxes. The minimum need level established by the Kansas Legislature for a family of three is $655. The federally established poverty level for a family of three

is $814 per month. Thus, $4 per hour still leaves a family of three well below the Legislature's need standard after taxes, and far below the federal poverty level. As mentioned above, 79 percent of the surveyed women earned less than $4 per hour.

- **Number Of Children** - The following table shows the percent of women in the survey by the number of children they have, and the number of children living with them.

Percent Of Surveyed Women By Number Of Children Living With Them

Number of Children	Percent By Total Children	Percent By Children Living With Them
1	32.4%	41.0%
2	28.4%	29.7%
3	20.7%	18.0%
4	10.4%	8.1%
5	3.1%	1.4%
6	2.3%	.4%
7 or more	2.7%	1.4%

- **Education** - Of the women in the survey, 40.5 percent have less than a high school education, 45.0 percent have a high school education, and 14.0 percent have more than a high school education. The remaining .5 percent did not answer the question.

Education Level

Less Than High School	40.5%
High School	45.0%
More Than High School	14.0%
No Answer	.5%

- **Job Training** (Other than in high school) - Of the women in the survey, 66.7 percent had no job training beyond high school. Of the 74 who had training, 19 had been in vocational/technical school, 12 had been in the Work Incentive Program, eight had been in the now defunct CETA program, seven had been in trade schools of various kinds, and the remainder had been in a variety of other training programs.

Job Training

No Training	66.7%
Some Training	33.3%

- **Day Care** - When asked if they knew anyone who could care for their children so they could work, 45.0 percent said they did not know where they could get day care. Of the remaining 119 clients in the survey who felt they could get day care, 72.7 percent said they could get day care from family or friends, 14.5 percent said they could use a day care center, and 12.8 percent said they could use paid day care in someone's home.

Ability To Get Day Care

No	45%
Yes	55%

Source Of Day Care For Those Who Say They Can Get Day Care

Family or Friends	72.7%
Day Care Center	14.5%
Paid Day Care In Someone's Home	12.8%

o **Age Of Client's Mother At First Birth** - The surveyed clients were asked the age of their mother when their mother gave birth to her first child. Of the surveyed clients, 20.7 percent could not answer the question, 38.3 percent said their mothers were teenage mothers, and 41.0 percent said they were not.

Percent Whose Mothers Were Teenagers At First Birth

Yes . . .	38.3%
No . . .	41.0%
No Answer	20.7%

The survey also showed that for clients who were mothers as teenagers, 45.7 percent said their mothers were also teenage mothers. But of clients who were not teenage mothers, only 28.8 percent said their mothers were teenage mothers. Thus, it appears that within the ADC population, the children of teenage mothers are more likely to become teenage mothers themselves.

Day Care And Transportation Are Cited By Clients As The Problems That Make It Most Difficult To Work

Surveyed clients were asked to pick, from a list of options, the problem that makes it most difficult for them to work. The following table shows the results.

Problems That Make It Most Difficult To Work

Day care too expensive or unavailable	19.0%
No transportation to work	16.7%
Not enough training	13.0%
Not enough education	9.0%
Not enough experience	7.6%
Would lose medical benefits	4.0%
Other answers	29.8%
No answer	.9%

The table shows day care and transportation are the single most difficult problems they face in seeking employment. The large other category included a wide variety of written-in answers, including:

- o No job available
- o Health problems
- o Pregnant
- o Pay too low
- o Can't afford gas and lunch

To gain further insight into the characteristics of the Kansas ADC population, we assessed the associations between the variables described above. Those results are presented below.

Having More Children Is Associated With Being On ADC Longer, Longer Lengths Of Time Since The Last Job Was Held, Having Less Education, And Having More Difficulty Getting Day Care

The relationship of the number of children the women have and other variables were addressed. Clear associations appear to exist in the following areas:

- o **Having only one or two children is associated with shorter stays on ADC.** Of women with one child, 51 percent had been on ADC less than two years. Of women with two children, 41 percent had been on ADC less than two years. Of women with three children, 29 percent had been on ADC less than two years. And again 29 percent of women with four or more children had been on ADC less than two years.

- o **Similarly, women with fewer children are more likely to have had a job within the last year.** The data show 29 percent for women with one child, 22 percent for women with two children, 20 percent for women with three children, and 17 percent for women with four or more children.

- o **Having four or more children appears to be associated with lower education levels.** Only 39 percent of the women with four or more children finished high school, while between 57 and 69 percent women with one, two, or three children finished high school.

- o **Women with more children are more likely to say obtaining day care is a problem.** The women with four or more children are somewhat more likely to say they could not find day care (51 percent), than women with one child (40 percent), women with two children (44 percent), and women with three children (48 percent).

The Women Who Became Mothers As Teenagers Had More Children, Less Education, And Were More Likely To Have Never Worked

National studies have shown a strong association between teenage childbirth and having more children and less future opportunities. The analysis of the ADC survey clients shows strong association between teenage childbirth and larger families and less education. The previous section showed larger families are associated with longer stays on ADC.

To be more specific about the effects of teenage motherhood in the survey population, the following table shows as the age of the mother at the birth of her first child goes down so does the likelihood of having more than two children.

Age Of Mother At First Birth And Family Size

Age At First Birth	Percent Having More Than Two Children
14 or younger	71.4%
15 to 17	47.1%
18 to 19	24.1%
20 to 24	24.4%
25 to 30	9.1%
Over 30	25.0%

Concerning teenage childbirth and education, 51 percent of the teenage mothers finished high school, while 69 percent of the mothers who delayed childbirth finished high school. One other significant finding is that women who had children as teenagers were much more likely to have never worked (16 percent) than the other women (7 percent).

The Women Who Completed High School Were Somewhat More Likely To Have Recently Worked, While Job Training Was Related To Higher Earnings On Their Last Job

Completing high school in and of itself was not strongly associated with the number of years the surveyed women had been on ADC, or the women's earnings in their last job. However, there appeared to be a moderate relationship between women who completed high school and the length of time since they last worked. Of the Women who finished high school 26 percent had worked in the last year, while only 18 percent of women without high school educations had worked in the last year. More strikingly, women without a high school education were much more likely to have never worked (18 percent) than women who finished high school (6 percent).

Like education, job training appears to have little relationship to the percentage of women staying on ADC for less than two years. But job training appeared to have some relationship to the percentage of women who worked in the last year. Of the women who had job training of some type 28 percent had worked in the last year and 12 percent were working at the time of the survey. For women without job training, only 20 percent had worked in the last year and 5 percent were working at the time of the survey.

Job training appeared to have a significant relationship to higher earnings on the last job and work experience. Of women who had job training, 35 percent earned over $4 per hour on their last job. The comparable percentage for women without job training was 10 percent. Also significant is that only one of the 74 women who had some type of job training had never worked, while 17 percent of the never-trained women had never worked.

Summary Of Key Survey Findings

Many conclusions could be drawn from these data. Some of the key findings are:

- A disproportionate number of ADC female heads of families (52 percent compared to 29 percent in the general population) are women who became mothers as teenagers.
- ADC clients who became mothers as teenagers are more likely than others to have more total children, not finish high school, and have never worked.
- ADC clients who have more children are more likely to have been on ADC for longer periods, have less education, are more likely to have not had a job for longer periods, and are more likely to have difficulty finding day care.
- Education and job training are to varying degrees related to higher earning in previous jobs and less time since the last job, and most strikingly ADC clients who completed high school or had job training were far less likely to have never worked.
- Of the surveyed clients, 66.7 percent had never had any job training outside of high school, and 40.5 percent did not have a high school education.
- Day care and transportation problems were cited by clients as the most significant impediments to employment.

These findings are generally consistent with those of national studies. These findings also support the notion that reducing teenage childbirth, reducing family size, increasing job training, and increasing job support such as day care and transportation could contribute to reduced dependence on public assistance. A previously mentioned national study concluded that women with fewer children are much more likely to leave ADC by working. Assisting clients prevent future unintended pregnancies may be the most significant single step SRS could take toward reducing dependency on public assistance. The number of children the ADC clients had was the only variable that appeared to be by itself strongly associated with the number of years they had been receiving ADC.

SECTION IV

KANSAS PROGRAMS THAT CURRENTLY ADDRESS THE PROBLEMS OF FEMALE HEADED FAMILIES IN POVERTY

The previous sections of this report provides information that can assist in formulating policies and programs to reduce poverty, and the problems associated with poverty, among female headed families. Before discussing the specific program options that could be considered, this section summarizes the major current state programs that address these issues. This section does not attempt to cover all relevant programs, since the programs that in some way affect these issues encompass nearly all of state government. Following are descriptions of the major programs. It is intended to give policy makers a working knowledge of these key programs before addressing the issue of what program or policy changes are in order.

Cash Assistance For Single Women With Children

The most basic programs for poor single women with children are those that provide income and food to enable those families to survive. The major Kansas programs in this area are discussed below.

The Aid To Dependent Children And Aid To Pregnant Women Programs

The Aid to Dependent Children (ADC) program is a joint federal/state funded program that provides income to poor families in which at least one parent is absent or incapacitated. Eligible families must have income and resources below established limits, must register for work unless exempt, and meet other program requirements. The ADC/Unemployed Parent program provides assistance to poor families in which one parent is unemployed if the nature of the unemployment meets the specified conditions described below. The unemployed parent must be considered the principal wage earner, he or she must have worked less than 100 hours in the previous 30 days, he or she must have worked in at least six quarters in some 13-quarter period that ended within the last year, and he or she must meet other requirements.

In fiscal year 1985, these programs distributed $82.7 million to a monthly average of 66,661 people. These clients received an average monthly grant of $103 per person. Of all persons receiving ADC, about 59 percent are white, 33 percent are black, and four percent are Hispanic. In May 1985 there were 18,698 ADC/Regular cases. Of those 18,698, 16,183 (86.5 percent) were families headed by a single parent. And 15,598 (83.4 percent of the total 18,698 cases) were families headed by single women. Assuming case sizes are fairly consistent regardless of whether or not the head of family is a single women, we can estimate the ADC/Regular program provided assistance to a monthly average of about 56,000 single women and their children in Kansas in fiscal year 1985.

Of the 15,598 single parent ADC cases, 401 or 2.6 percent were headed by single teenage mothers. There were in fact many more teenage mothers than these 401 receiving ADC. The 401 teenage mothers are those who were listed as the head of their families. Other teenage mothers are in families headed by their mothers or other relatives. The computer system cannot identify the

number of these teenage mothers. However, in the survey of ADC clients discussed earlier, 60 (or 20.5 percent) of the 292 clients who returned surveys indicated they had children and grandchildren living with them. Thus, of the total 18,698 ADC/Regular cases, there may be as many as 3,833 (20.5 percent of 18,698) in which a teenage mother lives with her mother, in addition to the 401 teenage mothers who head their own families.

The ADC/Unemployed Parent program does not serve single parents, but there were 215 married teenage mothers in this program in May 1985. These 215 cases represent 11.0 percent of all ADC-Unemployed Parent cases in May 1985.

In addition to providing ADC benefits for single (and some married women with a disabled spouse) women with children, Kansas also provides these benefits to some women who are pregnant through the Aid to Pregnant Women Program (APW). The APW program provides full ADC benefits to women who have no children, who are pregnant, and will meet all other ADC eligibility requirements at the time they give birth. Kansas covers these women under ADC through the entire pregnancy, even though the federal government pays its share only in the last trimester. In May 1985 there were 581 clients in the APW program. First time pregnant women who have low-incomes but would not be ADC eligible (e.g. a woman living with her employed husband) would be eligible for the General Assistance program if their income was low enough.

While there is no question the income assistance provided by these programs is significant for the recipients, it would be unfair to imply these programs fully meet the clients' income needs. Most ADC families can also become eligible for Food Stamps. But the cash assistance programs combined with Food Stamps and Low-Income Energy Assistance have not kept pace with inflation. The combined benefits of these programs in fiscal year 1986 ($561 per month maximum for a family of three) is 85 percent of the minimum need level as defined by the Kansas House Ways and Means Committee during the 1985 legislative session ($655). And that minimum established by the Legislature is only 80 percent of the federally established poverty level, meaning Kansas' combined benefits equal only about 69 percent of the federal poverty level ($814).

The General Assistance Program

Most women with children will receive ADC if they are on public assistance. But some married women who have children or are pregnant may be eligible for the General Assistance program. These women are relevant to this study because of the focus on providing adequate prenatal care. General Assistance clients are eligible for MediKan, which pays for prenatal care.

In fiscal year 1985 the GA program provided $13.0 million in income to a monthly average of 10,784 low-income Kansans. In May 1985 only 731 of those recipients were children -- 177 under one year old, 221 age 1 to 4, and 333 age 5 to 21. The 731 GA children are in 347 GA cases. Of those 347 GA cases with children, the adult female in the case was a teenager in 56 or 16.1 percent of those cases. There were also 107 single childless teenage women in the GA program. As mentioned above, pregnant women with no other children who are not eligible for the Aid to Pregnant Women program because they have a working spouse may be eligible for General Assistance if their income is low enough. But in May 1985 there were only eight such women in the GA program.

Medical Assistance For Single Women With Children

The Medicaid program is a joint federal/state funded program that provides payments for medical services to eligible low-income Kansans. Some clients not eligible for Medicaid are eligible for the state funded MediKan program which pays for nearly the same services. Services paid for under both programs include up to 12 physician office visits, inpatient hospital services including nonelective surgery and 48 hours for normal childbirth care, prenatal care, family planning, and prescribed drugs.

Who Is Eligible For Medical Assistance? Clients eligible for Aid to Dependent Children or Supplemental Social Security benefits are automatically eligible for Medicaid. Also, clients who would be eligible for either those two programs, except that their income is too high, may be Medicaid eligible in one of two ways. First, if their income is too high to receive Aid to Dependent Children benefits, but their income is below the Medicaid Protected Income Level ($435 for a family of three), they are eligible. Second, if their income is above the protected income level, but within a year their medical bills exceed the difference between their income and the protected income level, then they are eligible. (This route to Medicaid eligibility is called spenddown.)

Clients who are eligible for General Assistance are automatically eligible for the MediKan program. These are clients, for example, who do not meet Aid to Dependent Children requirements such as deprivation of parental support (two parents in family/father employed), but whose incomes are low enough to be eligible for General Assistance. For these clients there is no higher protected income level or spenddown that would allow them to be eligible when their incomes are just above General Assistance levels. Allowing a spenddown for some or all MediKan-type clients is one way Kansas could expand medical coverage to low-income Kansans who currently are uninsured. The size of that uninsured population in Kansas is not known.

When Are Pregnant Women Eligible For Medical Assistance? Eligibility for pregnant women is a particular concern because of the proven benefits of providing prenatal care. Women without children are generally not eligible for the Aid to Dependent Children program. But currently a pregnant woman is eligible for Medicaid from the time her pregnancy is confirmed if the child would be eligible for Aid to Dependent Children at the time of birth. That is, there must be a deprivation factor (absence, unemployment, or disability) and the family must meet all income and resource limits, and other program requirements. The unborn child is not counted in determining family size.

Pregnant women who meet all the Aid to Dependent Children eligibility criteria, except income, are eligible from the time of confirmed pregnancy if their income is below the protected income levels or they meet spenddown requirements.

Pregnant women who are not eligible for Aid to Dependent Children because there is no deprivation factor (e.g. the father is employed) are eligible for MediKan (General Assistance) if their income is below GA income limits and they meet other GA eligibility requirements. When Transitional General Assistance (TGA) and General Assistance Unrestricted (GAU) were split in 1983, pregnant women were put on the TGA program and then moved to GAU after the child was

born. This was confusing and provided lower benefits while the women were pregnant. In May 1985 pregnant women were added as a GAU category. Currently SRS is moving toward placing these pregnant women in the Medicaid program instead of MediKan. This will eliminate some copayments required of these women as MediKan clients (i.e. $1 for each physician visit) and will allow the state to get federal Medicaid dollars for these women. Some pregnant women who would not have been eligible for MediKan, because spenddown is not allowed, will become eligible for Medicaid when this change is made.

Special Eligibility Issues Related To Children. In addition to the children eligible for Medicaid under the circumstances discussed earlier, a November 1984 change in federal law required Medicaid eligibility for a new group of children. These are commonly referred to "Ribicoff children" after the Senator who developed the legislation. The Ribicoff legislation made two new groups of Kansas children under five years old (if born after October 1983) eligible for Medicaid.

- The first group are those children who were eligible for General Assistance and MediKan in the absence of the Ribicoff rules. These children became eligible for Medicaid, which means the federal government pays about half the cost of services for these children. The State of Kansas actually saves money on these children, since without Ribicoff the State would have had to pay the entire cost of MediKan services for these children. In May 1985 there were 156 of these Ribicoff children who would have been eligible for MediKan in the absence of the Ribicoff rule.

- The other group of Ribicoff children are those who would not have been eligible for MediKan without the new rule. These are primarily children who live in two-parent families (not eligible for Aid to Dependent Children), and whose families' incomes are too high to receive General Assistance, but are also in one of two situations:

  1. Their families' incomes are above the General Assistance limits, but below the Protected Income Level for Medicaid ($435 for a family of three), or

  2. Their families' incomes are above the Protected Income Level, but within a year their medical bills exceed the difference between their families' income and Protected Income Level. Thus, the Ribicoff rule creates a spenddown eligibility option for children under five years old in General Assistance-type families. The adults in these families remain ineligible for Medicaid and MediKan. One attractive feature of the Ribicoff rule is that intact families who face catastrophic medical bills, for an infant or child under age five, can receive medical assistance for that child.

  In May 1985 there were 50 of these Ribicoff children who would not have been eligible for medical assistance in the absence of the Ribicoff rules. Since the State pays about half the medical assistance cost for these children who would not otherwise have been eligible it costs the state additional money to serve this group of 50 children.

An Option For Adding Some Children To Medicaid At Little Cost To The State. It appears that in effect it may not have costed the State General Fund

anything to add these 50 children to the Medicaid rolls. The reason is that while the Ribicoff rules brought 50 new clients into the system for whom the State General Fund paid half of their medical services, the new rules also resulted in the federal government paying half the cost of medical services for the 156 clients whose services would otherwise have been paid for entirely by the State General Fund. An example illustrates the point.

In the example there are three Ribicoff children who would have received MediKan even without Ribicoff and one who would not have been eligible. This three to one ratio exists in the actual population of Ribicoff children.

Without Ribicoff	With Ribicoff
Child A Eligible Cost - $100 Funding - $100 State	Child A Eligible Cost - $100 Funding - $50 State $50 Federal
Child B Eligible Cost - $100 Funding - $100 State	Child B Eligible Cost - $100 Funding - $50 State $50 Federal
Child C Eligible Cost - $100 Funding - $100 State	Child C Eligible Cost - $100 Funding - $50 State $50 Federal
Child D Ineligible Cost - $0 Funding - $0	Child D Eligible Cost - $100 Funding - $50 State $50 Federal
Total Cost - $300 Funding - $300 State	Total Cost - $400 Funding - $200 State $200 Federal
Total Children Eligible - 3	Total Children Eligible - 4

In the example the State General Fund expended $100 less with the Ribicoff rules than without Ribicoff even though an additional child was served with the Ribicoff rules. Kansas has the option of serving children ages 5 to 21 under these same Ribicoff rules. If the three to one ratio exists in this age group as it does in the lower age group, then **the State General Fund would actually expend less than it does now if the Ribicoff rules were extended to children ages 5 to 21.** In effect this change would add children age 2 to 21, since the current Kansas rules only provide Ribicoff eligibility to children under five born after October 1983. Children born on that date are about age two now, and Kansas will not cover all three to five year old children under current rules until October 1988. **Assuming the number of Ribicoff-type children in the higher age group is comparable to the numbers in the lower age groups, extending the Ribicoff rules to the 2 to 21 age group would result in our serving about 450 additional children at no cost to the state.**

One potential pitfall in this analysis is the possibility that these newly eligible Ribicoff children may cost more per client to serve than the clients

who would have been eligible without Ribicoff. This issue deserves further analysis before considering expanding the Ribicoff program. The previously mentioned decision to make pregnant women on MediKan eligible for Medicaid has an effect similar to expanding the Ribicoff children. The State would save money on these clients, but also new clients who become eligible through the Medicaid spenddown option would enter the program and expand State costs. Like the Ribicoff children, the actual cost to the State of expanding Medicaid eligibility in this way depends on the number of women entering the system who were previously not eligible for Medicaid or MediKan and the cost per client for these new clients. These numbers are not yet known.

The Number Of Women And Children Served By Medical Assistance

In May 1985 there were 126,830 eligible Medical Assistance clients in Kansas. The following table shows those clients by age and sex.

Medical Assistance Eligibles By Age And Sex

Age	Male	Female	Unknown
Under 1	2,039	2,004	507
1	2,229	2,184	31
2-4	6,707	6,502	41
5-10	9,952	9,665	11
11-14	4,780	4,508	3
15-17	3,386	3,259	1
18-19	915	2,099	0
20-21	818	3,013	0
22-30	4,495	13,590	6
Over 30	13,145	30,932	8
Total	**48,466 (38.2%)**	**77,756 (61.3%)**	**608 (.5%)**

Grand Total - 126,830

Of the total 126,830 served, almost half (60,823) were under 20 years old. About half of the 60,823 children served are female (30,221). Of the total 126,830 served, 61.3 percent were female. After age 19, the number of eligible women far exceeds eligible men by 29,077 (47,535 compared to 18,458). The reason is primarily that most Aid to Dependent Children/Medicaid cases do not include an adult male. About 68 percent of Medical Assistance clients are white, 24 percent are black, and three percent are Hispanic.

While almost half of all Medicaid clients were under 20 years old, only about 19 percent of all Medical Assistance expenditures in fiscal year 1985 were for clients under 21 years old. (This percentage is 17 percent if Medical Assistance expenditures in state institutions are left out.) One primary reason for this is that less than one percent of the money spent on the very expensive adult care home program is for children under 21. Thus, while one out of every two Medical Assistance clients is a child, only one out of every five Medical Assistance dollars is spent on children.

Single Women And Their Children On Medicaid. Of the 73,275 open Medicaid cases in May 1985, 43,812 were headed by single females. But over half of

those were older women who did not have children (e.g. older women eligible for Medicaid as a result of their eligibility for Supplemental Social Security). Of the 73,275 cases, 18,897 or 25.8 percent were headed by single females with children. In these 18,897 cases headed by single women, there were 38,588 children. Included in the 73,275 cases there were also 581 cases eligible for the Aid to Pregnant Women program. These are pregnant women, who have no other children, who will be eligible for the Aid to Dependent Children program when their baby is born. Most of these women are single.

Of those 43,812 female headed families on Medicaid, 530 or 1.2 percent of those family heads were teenagers. In addition to these teenage mothers who head families, there are also teenage mothers receiving Medicaid who are members of a family headed by someone else. In the SRS survey of Aid to Dependent Children clients, 20.5 percent of the respondents indicated there were children and grandchildren living in their families. Assuming that most of the young mothers in these families are teenagers, then another 3,800 Medicaid cases include single teenage mothers.

The Medical Assistance Program Expended Over Half A Million Dollars For Prenatal Care In Calendar Year 1984

Earlier sections of this study indicated that adequate prenatal care is an important factor in preventing low birthweights and is a cost effective way to improve the health of low-income Kansans. Women who are eligible for Medical Assistance can receive prenatal care through physicians or local health departments that have physicians on staff.

Medicaid coverage is more extensive for pregnant women than for other Medicaid clients in two ways. First, there is no limit on the number of physician visits for prenatal care, whereas normally physician visits are limited to twelve in a calendar year. This expanded coverage for pregnant women is also available to pregnant MediKan clients. Second, pregnant Medicaid clients do not have to make copayments on any service related to pregnancy. For example, normally Medicaid clients must pay one dollar for every physician office visit and every prescription, but pregnant Medicaid clients are not required to make these copayments if the services are related to the pregnancy. At the present time pregnant MediKan clients, however, are required to make the same copayments as other clients even if they are pregnancy related.

In calendar year 1984, Medical Assistance expended approximately $550,000 for prenatal care for over 5,500 women. The maximum reimbursement of $111 for complete prenatal care is 56 percent of the regular fee ($200) charged by Medicaid physicians at the 75th percentile (i.e. 75 percent charge less than $200 and 25 percent charge more).

Despite Medical Assistance coverage of prenatal care, 32.1 percent of Medicaid clients in the birth certificate match study discussed earlier had fewer than nine prenatal care visits. Nine visits are considered minimally adequate. The birth certificate analysis showed Medicaid clients had a higher incidence of low birthweights (9.6 percent) than the general population. Also, the analysis showed low birthweights were much more common among Medicaid clients who had fewer prenatal care visits.

In order to increase the utilization of prenatal care among Medical Assistance clients SRS will begin a new program to encourage the utilization of prenatal care services by Medical Assistance clients in fiscal year 1987. In this proposed program the Department of Health and Environment through local health departments would provide prenatal risk reduction classes paid for by Medicaid to pregnant women covered by Medical Assistance. These classes would include preventive techniques such as no smoking and adequate diet, and would encourage utilization of prenatal care physician visits. These classes may be in groups or one-on-one through local health departments. The Department of Health and Environment, under this proposal, would expand its Healthy Start Program (home visits to mothers of newborns) to pregnant women. The program would target Medical Assistance clients. The home visits would reinforce the information gained in the classes and provide one-on-one support to encourage preventive techniques among these low-income pregnant women.

The increase in prenatal care would result in a decrease in the incidence of low birthweight infants among the Medicaid population. This would have a direct economic benefit to the State since low birthweight infants often require very costly intensive care. In the year and one-half preceding July 1985, there were 262 cases in which Medicaid clients appear to have received neonatal intensive care, based on a review of Medicaid claims data. The average hospital and physician costs for a random sample of 50 of those infants was over $15,000 for each infant. This compares with a cost of about $700 for a healthy infant. As mentioned earlier the National Institute of Medicine concluded over three dollars in medical care could be saved for every dollar spent on prenatal care. To provide a minimum of nine prenatal care visits to Medicaid clients found in the earlier described SRS study of Medicaid recipients to have not received an adequate number of visits, would cost about $75,000. Based on the Institute of Medicine's conclusions, in return for this prenatal care expenditure we would save $225,000 in medical costs for low birthweight infants.

Early And Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a service available to Medical Assistance clients. It is a particularly relevant service for this study since it is directed at children and can be of benefit to teenage mothers. EPSDT provides preventive health care or immediate remedial care for the prevention, correction, or early control of abnormal conditions in recipients from birth through age 20. Screenings are conducted on the following schedule.

Age At Time Of Screen	Next Screen Due In
Newborn	1 month
1 through 23 months	6 months
24 through 59 months	1 year
5 through 14 years	3 years
15 through 17 years	3 years
18 through 20 years	no more screens

An EPSDT screen includes a medical history and examination, vision and hearing tests, family planning assessments for adolescents, and a nutritional assessment. EPSDT services are considered to be cost effective preventive services. Yet only 44 percent of eligible Medical Assistance clients in

calendar year 1984 used EPSDT services. Increased outreach by SRS to encourage the use of EPSDT would be a relatively low cost method of improving preventive medical services. Target groups for such outreach could include teenage mothers and their children. Specialized caseworkers for teenage mothers, who could encourage the use of EPSDT services, is one of the innovative approaches discussed in Section V of this study.

Medical Assistance Family Planning Services

Medical Assistance services include family planning. The Kansas Medical Services Manual defines family planning as a means of enabling individuals of childbearing age to determine freely the number and spacing of their children. The manual states that family planning can be provided by family planning clinics, local health departments, and physicians, and can include the following:

- Consultation and examination,
- Laboratory examinations and tests,
- Natural family planning methods, and
- Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception through chemical, mechanical or other means.

Abortions are **not** considered family planning services.

In calendar year 1984, Medical Assistance expended almost $70,000 to provide family planning services for 2,528 clients. These expenditures do not include laboratory costs, which are billed separately.

These 2,528 recipients represent about 10 percent of the female Medicaid clients from 15 years old through age 30. Federal rules require that Aid to Dependent Children clients be informed about and referred to family planning. Although these referrals are made, a review of SRS's procedures for making these referrals may be worthwhile in order to increase the utilization of family planning services.

Specialized caseworkers for teenage mothers or first-time mothers would be one approach to encouraging utilization of these services. This would be a logical group on which to focus family planning services since, as was discussed earlier, teenage mothers tend to ultimately have more children than other mothers, and women with more children have a harder time getting off public assistance. This initiative would be particularly low cost for Kansas since the federal government reimburses the State for 90 percent of family planning expenditures, rather than the usual 50 percent.

Department Of Health And Environment Programs

The Kansas Department of Health and Environment is charged in part with the responsibility to promote the health of Kansans by providing community and personal health services. In doing so many of its programs affect the single mothers that are the focus of this study, and affect more specifically single mothers who are SRS clients. Following is a description of four Health and Environment programs that affect the welfare of low-income single women with children.

Maternal And Infant Care Programs

Maternal and Infant Care Programs operate in ten Kansas counties through local health departments and are designed to improve the health of teenage mothers and their children. Other high risk mothers are also served. Services provided include physician or nursing supervision before and after birth; nutritional assessment and counseling; social work services; infant care and parenting education; and follow up contacts for one year after delivery. Preliminary studies by the Department of Health and Environment indicate these Kansas programs reduce infant mortality and low birthweight significantly.

The ten counties with programs are Douglas, Geary, Johnson, Leavenworth, Reno, Riley, Saline, Sedgwick, Shawnee, and Wyandotte. The programs are funded through local, state, and federal sources. Special programs have been funded in Wyandotte, Shawnee, Geary, and Sedgwick Counties to reduce black infant mortality. Eligibility criteria for the programs vary at the local level. Some programs serve primarily low-income persons who have no medical insurance and are not on Medicaid. Johnson County's program serves primarily Medicaid clients because of an inadequate number of Medicaid providers in Johnson County.

In calendar year 1984, 1,776 mothers and 1,065 infants received Maternal and Infant Care Programs services. Of the total mothers served, 80 percent were teenage mothers and 60 percent were single mothers. Also, 42 percent of the clients who gave birth in 1984 were Medicaid clients at the time of the birth.

The percentage of Maternal and Infant Care clients also enrolled in the Women, Infants, and Children (discussed below) program varies by county from 90 to 99 percent. Most of the counties report referring all their clients to the Healthy Start Program (also discussed below). In Wyandotte County all women under 18 are referred to the Healthy Start Program, and about 30 percent of the women 18 or over are referred (primarily those with the highest risk). The Women, Infants, and Children Program and the Healthy Start Program are described below.

The Women, Infants, And Children Program

The Women, Infants, and Children Program provides supplemental food and nutritional counseling to women who are pregnant, breastfeeding, or up to six months post partum, and to children up to age five. The program is federally funded. Each recipient receives a health and diet assessment. Based on individual needs a monthly food prescription is provided that includes food such as iron-fortified infant formula, milk, cheese, eggs, and peanut butter. Clients pick up vouchers each month which are used to purchase only the prescribed foods at authorized grocery stores. To be eligible the family's income must be below limits set by the National School Lunch Act ($15,651 annually for a family of three).

Nationally many studies have been done of the Women, Infants, and Children (WIC) Program. After reviewing these studies in 1984, the federal General Accounting Office concluded there is considerable evidence that the program

increases average birthweights and decreases the percentage of low birthweight infants.

In April 1985 the program was providing services to 23,637 clients, including 3,216 pregnant women, 923 breastfeeding women, 7,187 infants under one year old, and 12,311 children ages one to five. Of the women in the program, 18 percent were 18 years old or younger at the time of conception. The number of WIC clients who are also on public assistance is not known. But we do know 37 percent of all WIC clients are in families that receive Food Stamps.

The Healthy Start Program

The Healthy Start Program provides visits to the homes of new mothers by trained lay visitors (not nurses or social workers). The visitors provide support to the family, teach parenting skills, and encourage utilization of preventive health systems (such as EPSDT). The program's objectives are to increase the use of preventive health services and reduce the incidence of abuse and neglect among young children. Any new mother can receive services, but priority is given to teenage and single mothers, and mothers with a high risk of abuse or neglect (such as mothers with a previous history of abuse or neglect). About 10,000 women receive Healthy Start Services annually. There are no data on the percentage of clients served who are also public assistance recipients.

The Family Planning Program

Local and federal dollars fund family planning clinics in 65 Kansas counties. These clients are among the providers used for family planning by Medicaid clients, but they provide services to other clients as well. Priority for services are given to low-income women.

In calendar year 1984 these clinics served 41,488 women, 27 percent of whom were under 20 years old. The Department of Health and Environment indicated additional clinics are needed to meet demand for services, and they reported ten of the clinics have waiting times for services of over one month.

Child Support Enforcement

As discussed earlier in this report, child support from absent parents is frequently not paid. One way to elevate the economic status of single women with children is to improve the legal and administrative processes for ensuring women receive the child support they are entitled to. Within SRS, the Child Support Enforcement Program assists Aid to Dependent Children clients and other women to receive child support payments, that have been ordered by courts, from absent spouses.

Generally the Child Support Enforcement process for Aid to Dependent Children clients is as follows:

- All Aid to Dependent Children (ADC) cases, in which eligibility is based on the absence of a parent, are referred to the Child Support Enforcement Program.

- o Based on information contained in a ten-page form filled out by the client, cases are categorized as active or inactive. There are about 20,000 active ADC cases out of about 70,000 total ADC cases. (These cases include women who are no longer on ADC, but for whom SRS is still seeking child support from the absent parent to offset the cost of the ADC payments.) The highest priority cases are made active cases. Those priority cases are those in which:

  - The location of the absent parent is known.

  - There is an existing court order for child support payments to be made. (Child Support staff indicated court orders exist in 20 to 50 percent of ADC cases.)

  - Paternity has been established and is not an issue. (About 150 cases in which paternity is not established are made active cases so that paternity cases are not left completely out of the process.)

- o After a case becomes active, and if child support payments are not being made, a Child Support Specialist develops a case plan which includes:

  - Locating the absent parent, if that is necessary, by using phone books, income tax records, and other computerized data systems.

  - Establishing paternity, if that is necessary, by getting the father to voluntarily acknowledge paternity, or by asking a court to determine if paternity can be legally established.

  - Seeking a voluntary commitment by the absent parent to make payments, if a court order does not exist.

  - Seeking a court order for child support if a court order does not exist and the father does not agree to make voluntary payments.

- o Once a schedule of support payments is established, SRS monitors and enforces those orders through the following processes:

  - Notices are sent to some absent parents when payments are late, although SRS does not have the ability (manpower and equipment) to send these notices in all cases.

  - In some parts of the State absent parents are billed monthly. In two to three years a new automated system should enable SRS to send these bills statewide.

- o If child support payments are not made regularly, SRS has several options for ensuring payment, including:

  - With a court order wages can be withheld directly from an employee's paycheck and sent to SRS for child support.

  - SRS can petition the court to issue a contempt of court citation. The courts can, but seldom do, put the absent parent in jail for failure to pay.

- With a court order SRS can obtain monies due to the absent parent, such as income tax refunds, state payments to contractors, and unemployment insurance.

- Placing a lien on property, making it impossible for the absent parent to sell the property without paying SRS.

Child support payments for Aid to Dependent Children clients go directly to SRS and are used to offset the costs of the ADC grants. Until recently SRS has provided Child Support Enforcement services to a relatively small number of non-ADC clients. These clients had to pay a fee to receive those services. Recently this fee has been eliminated along with other changes designed to strengthen the Child Support Enforcement Program which are discussed below.

Recent Changes In The Child Support Program Should Increase Payments

Legislation passed by the 1985 Kansas Legislature, in response to a 1984 federal initiative, resulted in several changes that were effective July 1, 1985 and should increase child support collections. Two of the changes are most significant. First, when child support payments are delinquent for 30 days a court order for wage withholding will be established routinely. In the past withholding was not always set up this quickly after delinquency began. Another key difference from the past is that once these wage withholding arrangements are established by the courts they will continue indefinitely instead of the court order for withholding lasting only for a specific period of time.

The second key change, already mentioned above, is that SRS will provide free child support collection services to non-ADC clients and SRS will publicize the availability of these services. All these changes combined are expected to increase child support collections from $11.3 million in fiscal year 1985 to an estimated $22 million in fiscal year 1986. Approximately 60 new SRS employees, most assigned to non-ADC cases, have been added to handle this new workload.

In addition to the changes mentioned above, the Governor's Advisory Commission on Child Support is working to establish uniform guidelines for courts in determining the amount of child support that should be ordered. In sum, Kansas has taken steps to expand its Child Support Enforcement Program.

But despite these changes there appear to be further steps that could be taken to increase child support collections. As mentioned earlier, about 50,000 of the potential 70,000 ADC child support cases are not actively pursued. These are generally the more difficult cases in which court orders do not exist, the location of the absent parent is not known, or paternity has not been established. Although the data to be certain do not exist, Child Support staff believe it would be possible to establish child support payments in about half of the inactive cases if sufficient staff to pursue those cases were available.

In addition to adding manpower to increase Child Support Enforcement activities, further statutory changes could be considered to increase the benefits of child support for single women and their children. Wisconsin is

studying a pilot project in ten of its counties that requires that child support payments be withheld from income in all cases from the time of the court order. That is, income withholding would begin immediately without waiting for the payments to become delinquent, at which time it may be more difficult to enforce the support order. The results of this study should help Kansas decide if further statutory changes are advisable.

Employment Programs For Single Women With Children

For poor single mothers employment is the only way out of poverty and off public assistance unless they receive increased child support payments or have a major change in circumstances such as marriage or children leaving the home. A national study found about a third of those who leave the Aid to Families with Dependent Children (AFDC) program do so because of increases in their own earnings. Another third leave through marriage or reconciliation, 14 percent leave when their children leave or grow up, and the rest leave for other reasons. 75/

Thus clearly a significant number of ADC women exit the program through employment. Many of those who do not get jobs want to work, but are unable to do so because of a lack of skills and support services such as day care. The survey of Kansas ADC clients completed for this survey indicated 40.5 percent of the clients did not have a high school education, and 66.7 percent had no job training. Lack of day care and transportation were most commonly cited as reasons for being unable to work.

Given the success of some women in leaving ADC through work, and the clear road blocks to work for other ADC clients, work programs would seem to have great potential for reducing welfare dependency. The following sections describe the primary work program available to these women, the Work Incentive Program (WIN) and related programs, and describes some problems and issues surrounding the WIN program.

The Work Incentive Program (WIN)

All ADC clients are required to register for the WIN Program unless exempt. Among those exempt clients are those who are the parent or relative providing care for a child under six, women who are at least six months pregnant, persons over age 64 or under age 16, and incapacitated persons. The WIN program is operated jointly by SRS and the Department of Human Resources. The program operates differently in counties that have full WIN services and those that do not. The counties with full WIN services are Douglas, Sedgwick, Shawnee, and Wyandotte.

The WIN Program In Counties That Have Full Services. The WIN program in these counties works in the following way.

- o Non-exempt clients are referred to the local Department of Human Resources WIN office.
- o Clients who are immediately job ready are sometimes referred to a job from the "Job Bank." These clients generally have job experience and immediately saleable skills. The Job Bank is developed by the Department of Human Resources and includes lists of jobs known to be

available. Some of these "Job Bank" jobs are developed through contracts with employers. For example, the Department of Human Resources identifies referred clients who are qualified for certain jobs at Goodyear in Topeka. Goodyear hires first for certain jobs from clients referred through the Job Bank. The Department of Human Resources also works with employers to encourage hiring through the Job Bank by helping employers take advantage of the federal tax credit for hiring certain types of unemployed persons.

- Clients who are not immediately employed through the Job Bank go through an appraisal interview with an SRS social worker and Department of Human Resources employment and training interviewer. The employment and training interviewer evaluates the client's work history, education, veteran status, and other factors related to the client's employability from the employer's perspective. The social worker evaluates the client's barriers to work from the client's point of view, such as lack of child care, lack of transportation, health problems, and etcetera.

  The appraisal interview results in a decision concerning whether or not the client is immediately employable, employable with available social services, or not employable due to problems that social services cannot address (either because of a lack of social service funds or because the problem is not solvable through social services). Data on the reasons clients are found "not job ready" are not kept, but in general the most common reasons are a lack of available child care, a lack of transportation to either day care or jobs, and chronic (but not disabling) health problems of the applicant or the applicant's family.

After the appraisal interview the client receives one or more of the following available WIN employment services.

- Job Search - A written job search plan and job goal is written for the client. The client is required to come into the WIN office at least three times per week for job referrals, and they are required to look for jobs on their own. Job Search lasts for up to eight weeks.

- Community Work Experience Program (CWEP) - In this option clients are required to work in public or non-public entities up to the number of hours times $3.35 (minimum wage) that equals their public assistance grant. There is a 16 day per month limit. Examples of jobs include SRS clerical work, and YWCA clerical and child care work. SRS pays these clients up to $20 per month for transportation if they work up to 10 days, and $30 if they work more than 10 days. CWEP includes a one-day orientation (including important job concepts such as neat appearance and timeliness). CWEP is also available in 15 non-WIN counties and is provided to General Assistance as well as ADC clients.

- Job Club - The purpose of Job Club is to provide confidence building and job seeking skills to allow public assistance recipients to be competitive in the job market. The basic program is two weeks in length. The first week clients participate in classroom instruction providing peer group support, self-assessment of skills and interests, and goal setting. Job seeking techniques are practiced such as completing appli-

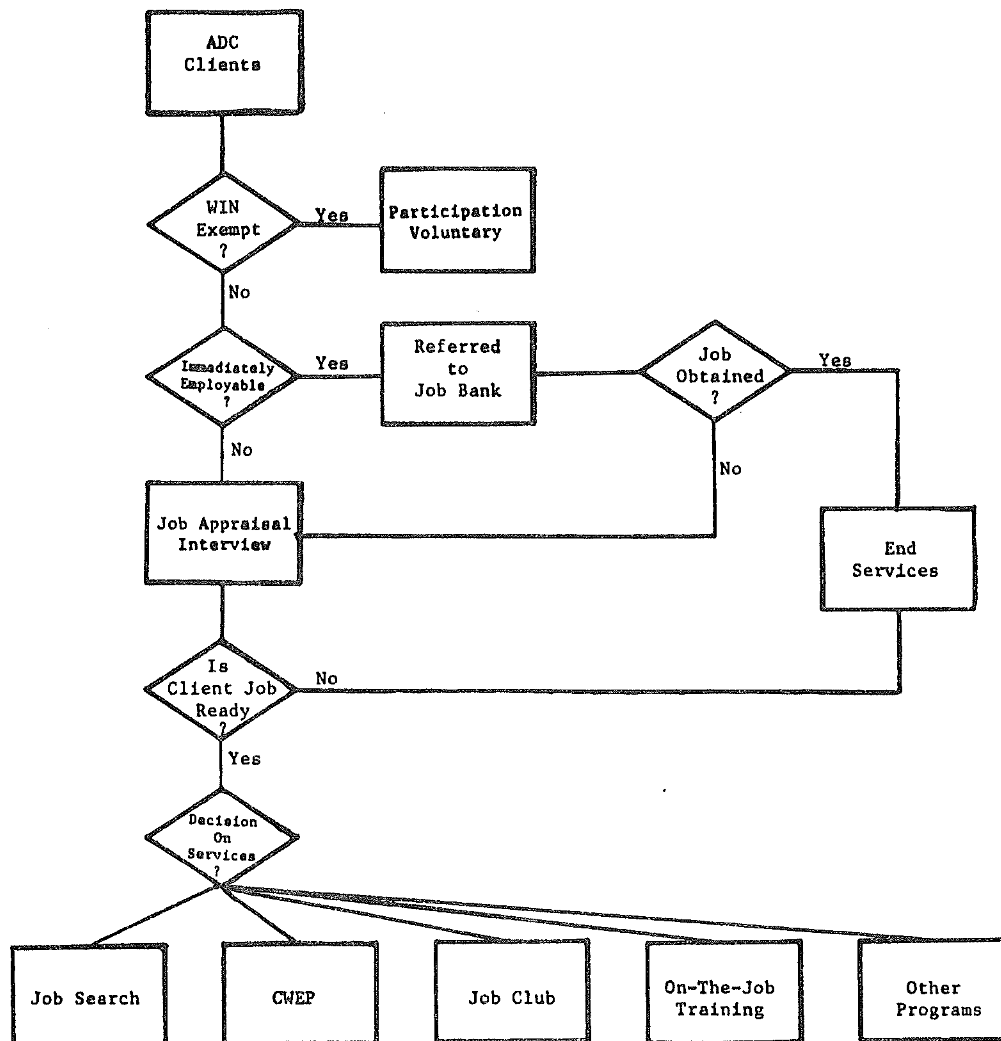
cations, interviewing, resume development, finding jobs that are not advertised, and obtaining job interviews through use of the telephone.

During the second week, Job Club participants call local employers using telephone techniques which describe their work skills and assets. Job interviews are obtained from these calls and completed by the participants. Since 80 percent of job openings are never advertised, this allows the Job Club participant to obtain employment quickly. Recipients who do not obtain work within one month are referred to the Job Training Partnership Act Program (JTPA) or continue in individual Job Search with follow-up by Job Club staff for 90 days. Items needed for Job Search or employment such as transportation, clothing, General Education Development (GED) testing for a high school diploma, and others, are provided through community resources or Job Club funds.

The Job Club Program also operates in three non-WIN counties. Although used by some ADC/WIN clients, Job Club services are used primarily by General Assistance clients.

- <u>On-The-Job Training</u> - In this option the Department of Human Resources pays employers up to 50 percent of the client's wages for up to six months as an incentive for the employer to hire WIN clients. This option is seldom used because of its high cost. A similarly costly option that is not currently used is public service employment, in which the client's full salary and benefits for a public sector job is paid by WIN for up to six months.

- <u>Other Options</u> - Some WIN clients receive services through other programs, such as SRS's Rehabilitation Services or the Job Training and Partnership Act program.



In addition to the employment services listed above, some WIN clients receive $3 per day for transportation and lunch from the Department of Human Resources. These payments can continue for two weeks after a client gets a job. Also, part of SRS's role in the WIN program is to provide social services that enable clients to successfully train and search for jobs. But funds to provide such services are extremely limited.

Day care is the primary social service provided by WIN, but in fiscal year 1985 SRS paid for day care for only 206 children of WIN clients. In federal fiscal year 1984 there were 4,706 WIN clients found to be job ready, and 7,600 potential WIN clients who received no services because they were found to be not job ready. Many of those 7,600 not-job-ready clients would have been found job ready if day care were available. Clearly, the 206 day care slots for WIN clients is inadequate, yet, in fiscal year 1986 a decrease in funds will result in fewer (about 148) WIN mothers getting day care paid by SRS.

SRS WIN workers can refer clients for other social services, such as family counseling, but no funds are available to provide such services to WIN client beyond those provided by WIN Social Workers themselves. Generally, WIN Social Workers do not have time to provide any in-depth services on their own.

The WIN Program In Counties That Do Not Have Full Services. Even though there is no WIN staff in any but the four WIN counties, non-exempt clients are still required to participate in a jobs program. Clients in these counties are required to do a job search, which involves making at least five job contacts per month and reporting the contacts to their income maintenance workers. Clients in the 15 non-WIN counties that have CWEP programs must register for CWEP. Clients who register for CWEP may or may not be placed in CWEP jobs, depending on whether or not enough CWEP positions are available.

In non-WIN counties ADC clients who are receiving Food Stamps must participate in the Food Stamps job search program, which requires 12 job contacts each month (seven more than if they were only receiving ADC). WIN clients in WIN counties are exempt from the Food Stamp job search program.

Most Single Women With Children On ADC Do Not Get WIN Services, Either Because They Are Exempt Or Found Not Job Ready

In federal fiscal year 1984, 13,372 ADC clients had WIN appraisal interviews. Most of these clients were required to register for WIN, meaning they do not include the 65 to 70 percent of single mothers on ADC in Kansas who have children under age six. Some of the registered clients were registered and later found to be not eligible for ADC. Of the remaining 12,306 ADC eligible registered clients, 7,600 or 61.8 percent were found not to be job ready. The other 4,706 clients were found job ready and actually received one or more WIN service. About half of registered WIN clients are white, 40 percent are black, and four percent are Hispanic.

The 4,706 job ready clients received primarily job search and CWEP services. The following shows the number of clients who received various WIN services.

Service	Clients
Job Search	2,323
CWEP	1,103
Public Service Employment	111 (a)
On-The-Job Training	93
Receiving Services Through JTPA or Other Program	1,200

(a) Public service employment is not currently used.

Of the 4,706 job ready clients served, 2,122 had jobs at the end of the year. We do not know the extent to which those jobs are attributable to the WIN services. While there is little question that WIN services have value, a 1982 national study by the General Accounting Office found about half of WIN clients who got jobs said the WIN services did not contribute to their getting the jobs. One major reason for this is the program serves those who are already job ready, and these are the clients most likely to get jobs on their own.

In sum, the WIN program addresses only a fraction of the employment services needed to help low-income single mothers to become independent. From 65 to 70 percent of these mothers are exempt from the program. Few of the exempt clients volunteer for the program, in part because SRS does not make a concerted effort to encourage these exempt clients to participate. One reason they are not encouraged to participate is that funds to serve even those who are required to register are inadequate. Of those required to register, over 60 percent are not served because they are considered not job ready, most because funds to provide day care and other needed social services are not available. Finally, for those who are job ready, most do not receive employment training because the funds for expensive training programs are not available.

SRS Should Consider Including Mothers Of Young Children In The WIN Program

Mothers of children under six are exempt from the requirement to register for WIN. Yet, as mentioned before, a recent national study showed that two-thirds of women who leave ADC through work are mothers of children under six. 76/ Many believe encouraging women to stay on ADC in these early years by exempting them from employment programs makes it more difficult for them to get back into the workforce later.

Some states have removed the WIN exemption for some women with children under six in order to involve these women in work programs. This option should be considered. Another option is to encourage these women to voluntarily register for WIN. However, not many women under either option will be able to take advantage of WIN services if additional funds for day care are not available.

Since late 1981 the State of Oklahoma has registered all women for WIN regardless of the age of their children. Day care services are extensively provided to make it possible for significant numbers of these women with small children to be declared job ready. Consistent with national studies Oklahoma has found almost 70 percent of its WIN clients who get jobs are women with children under six.

SRS has already taken a step in the direction of getting more women into the jobs programs by requiring Aid to Pregnant Women (APW) clients in Wichita to register for the CWEP program if they are less than six months pregnant. Although registration is required, placement in a CWEP job is voluntary because most will soon be six months pregnant and placement is voluntary at that time. In May 1985, when the program began, there were 24 APW clients required to register. Of those 24, 20 women indicated they wanted to be placed in a CWEP job. The local health department has agreed to provide two hours of prenatal care classes at the worksite (the SRS area office) for these clients. CWEP staff also discuss prenatal care with the women and encourage them to make doctor appointments.

The Need To Extend Medical And Other Services After Employment In Order To Increase Work Incentive And Job Retention

Many employers of women in low wage occupations do not provide medical insurance. The fear of losing medical benefits provided to public assistance

clients, combined with the costs of day care and transportation can serve as powerful disincentives for low-income women to work and keep their jobs.

SRS does currently provide some benefits in these areas after employment. Women who leave ADC due to earned income receive four months of extended Medicaid benefits. ADC clients who lose ADC eligibility solely because of certain work deductions which lapse after four months of ADC eligibility (called 30 and 1/3 deductions), receive extended Medicaid coverage for nine months after ADC ineligibility. However, these extended medical services are not available for women who have been eligible for General Assistance and leave the program due to work income.

Concerning transportation, some WIN clients receive a transportation allowance for two to four weeks after a job begins. Again, General Assistance clients do not receive this assistance. Concerning day care, SRS does provide day care services to some working low-income women. But funds for day care are very limited. The number of children receiving SRS day care services has declined from 5,298 in fiscal year 1980 to 2,481 in fiscal year 1985. In fiscal year 1985, only 206 children of WIN clients received day care services.

Providing extended medical benefits, transportation assistance, and day care to more women after they leave public assistance should be priorities if we hope to increase the number of women becoming independent through work. Finally, current rules limit to one year the time day care can be provided to ADC clients. This policy is being modified so that teenage mothers who need day care to complete high school or an SRS training program can receive those services for more than a year.

The Job Training And Partnership Act Program

As mentioned above, some WIN clients receive services provided by the Job Training and Partnership Act Program (JTPA). JTPA is operated through the Department of Human Resources and the Kansas Council on Employment and Training. JTPA serves unemployed men and women.

JTPA was created by a 1982 federal law and replaced the Comprehensive Employment and Training Act. JTPA's national funding level in federal fiscal year 1985 was $3.6 billion compared to CETA's $9.4 billion budget in fiscal year 1979. JTPA is different from CETA primarily in that it does not utilize public sector employment. JTPA services focus on training leading to private sector employment.

More specifically, JTPA provides on-the-job training, classroom training for adults, and work experience for youth. In the period from October 1983 to April 1985 JTPA in Kansas provided services to 9,939 clients. Of those served, 75.8 percent were employed by the time the JTPA case was closed. This very high placement figure may be the result of JTPA focusing its services on clients who can be placed with a minimum of assistance.

Of the total clients served by JTPA, 48.4 percent were women and 20.7 percent were single parents with children. Almost 80 percent of these single parents were women. Of the total served, 15.8 percent were Aid to Dependent Children (ADC) clients. Placement rates for single parents (67.2 percent) and

ADC clients (59.1 percent) were below the overall placement rate of 75.8 percent.

Programs For Abused And Neglected Children

Earlier this report discussed abuse and neglect of children as one of the costs of poverty among single mothers. National studies show that abuse and neglect occurs most frequently among low-income families. 77/ SRS programs address these problems in two ways. First SRS provides family services to help families overcome the problems that led to the abuse or neglect. Second, SRS provides foster care placements for children who cannot remain in their homes as a result of abuse or neglect. To reiterate some of the evidence of the link between poverty and abuse/neglect, in Kansas about 40 percent of foster children are from families that either were eligible for Aid to Dependent Children or would have been eligible if the family applied. Also, over half the recipients of Family Support Worker services (described below) are public assistance clients. Finally, in a recent period 35 percent of suspected abuse/neglect cases involved public assistance recipients.

SRS Family Services

The Family Services Program is designed to assist parents in fulfilling their child rearing function. Emphasis is directed toward maintaining children in their own homes or returning children to their families following a separation. The population served is comprised of children whom SRS finds to be abused, neglected, or in need of care for other reasons. Program components are family services provided directly by social workers and family support workers, as well as services purchased from private providers. These are specialized child welfare services for those children whose families are unable to carry out their parenting responsibilities. In Fiscal Year 1985, there were each month an average of 4,700 families participating in one or more components of the program. Each component is discussed below.

Direct family services provided by area field staff (social workers) are generally limited to handling short-term crisis situations, and are as intensive and intrusive as necessary for families to achieve and maintain a minimal but acceptable level of family functioning for the maintenance of their children in their homes. It is the responsibility of the professional social worker to assess family strengths and weaknesses and assist them in formulating a plan to correct the deficiencies in the home.

The purpose of the Family Support Worker component is to teach families those skills needed to maintain their children in their own homes. Services are geared to sustaining family strengths and to improving the capacity of parents to provide an acceptable level of parenting skills. Services are provided by SRS-employed paraprofessionals, and may include the following: teaching basic homemaking and parenting skills, assisting the family in accessing necessary community resources and services, assisting the family in the development of coping skills, and providing support systems to families. These services are provided to avert separation of the child from the family, whenever possible, or facilitate a timely return to home when separation is necessary.

The Purchase of Service component provides additional resources to further the goals of the program. The services that SRS purchases from other agencies or individuals cannot be provided by existing SRS resources, cannot be obtained without cost from any other source, and cannot be obtained directly by the client. In Fiscal Year 1985, SRS purchased the following: individual, marital and family therapy; psychological assessments; protective service and special needs day care; interpreter services for foreign speaking and speech/hearing disabled individuals; transportation services to assist families in accessing needed services; exterminator services to assist in providing a safe and sanitary home environment; and parent education classes. During Fiscal Year 1985, 579 plans for purchased services were written with a goal of preventing family dissolution; and 240 such plans were written with a goal of reunifying separated families. In addition, the agency purchased specialized in-home family services. There were 8,306 hours of in-home services purchased from three major purchase of family services contracts which include both individual family therapy (7,759), and group therapy (547). An estimated 83 percent of family services clients are white, 14 percent are black, and three percent are Hispanic.

The Foster Care Program

The Foster Care Program pays for maintenance (primarily food, clothing, and shelter) of children in family foster care, and for maintenance and services (primarily counseling and supervision) in residential facilities. Services provided to children in foster care by social service field staff include counseling, conducting administrative reviews (or other periodic reviews), and developing case plans. Developing a case plan includes: compiling social history information; documenting the need for placement; ensuring the appropriateness of the placement; ensuring that the child receives proper care and treatment while in placement; participating in family services to insure implementation of a timely reunification plan or implementation of another permanent plan where appropriate; conditional release supervision for a juvenile offender; determining a child's eligibility for the various foster care funding sources; and the preparation of periodic court and central office reports.

The Crittendon residential facility in Topeka is particularly relevant to this study since it is the only foster care facility in Kansas licensed to care for foster children who are pregnant or who have children. Crittendon serves up to six of these women under 18 and their children (the limit of six includes the children). Crittendon also provides residential services for 12 additional foster children who are not pregnant and do not have children.

The young mothers typically stay at Crittendon until their children are six months old. While at Crittendon these young mothers receive intensive counseling to help them provide proper child care, to help prevent these mothers from abusing or neglecting their children, and to help these mothers stay in school. Day care services are also provided to enable the mothers to stay in school.

There may be other young mothers or pregnant teenagers who are foster children in Kansas, but data on their numbers do not exist. These other teenage mothers may be placed in family foster care or in their parent's home on a trial basis.

Mothers Who Receive Public Assistance Are A Logical Target Group For Services Designed To Prevent Abuse And Neglect

SRS's Office of Analysis, Planning, and Evaluation is currently studying SRS's Family Services Program to assess its effectiveness in preventing abuse and neglect. Most of those services are directed at clients who have already abused or neglected their children or are found very likely to do so in the near future. One option this upcoming study will discuss is investing more funds in services designed to prevent abuse and neglect among parents who are considered high risk by some criteria, but have not been reported to SRS as having abused or neglected their children.

A logical target group for these services that seek to prevent abuse and neglect before it begins is the Aid to Dependent Children (ADC) population since a large percentage of persons found by SRS to be abusing and neglecting their children are ADC clients. One approach, for example, would be to provide classes in parenting skills to all ADC clients, or a subset of ADC clients.

The Youth Center At Beloit

SRS operates four youth centers that provide residential services to young men and women who have committed misdemeanors or felonies. The Youth Center at Beloit serves only women and is relevant to this study for two reasons. First, a startling percentage of the Beloit Center's residents are victims of abuse or neglect. Thus, the debilitating effects of poverty, which has links to abuse and neglect, also apparently has links to juvenile delinquency. Second, Beloit residents are high risk candidates themselves for becoming poor single mothers and potentially abusive mothers. Programs at the Beloit Youth Center address these potential problems through vocational education and parenting education.

To develop an example of the kind of problems the Beloit residents have, several case files were reviewed. In one case a 17 year old resident had been placed at Beloit after having stolen a credit card from her foster parents and been found by the courts to be a juvenile offender. This young woman had been placed in SRS custody previously. SRS records show she came from a low-income family, had a father who was reported to be an alcoholic, and had been sexually abused from the age of 5 to 13 years old. The young woman had been placed in several different foster homes by the time the credit card was stolen. She was described by social workers as impulsive, immature, promiscuous, and lacking self confidence.

In June 1985 there were 76 residents at Beloit. Of those, 43 or 56.6 percent were SRS-confirmed past victims of abuse or neglect. Another 14 or 18.4 percent were suspected victims of abuse or neglect. The average age of women admitted in fiscal year 1984 was 15 years and 7 months. Only 18 percent of those residents had parents who were married at the time the resident entered Beloit. The average length of stay for women leaving Beloit in fiscal year 1984 was 11 months and 12 days.

Programs At The Beloit Youth Center

Beloit residents progress through levels in which they are given increasing levels of responsibility as a reward for appropriate behavior. Residents and

staff meet each week to discuss their progress toward meeting specified behavioral goals, such as controlling temper or completing school work.

Every resident entering Beloit goes through a 60-day short program. The first 21 days include evaluations by psychologists and social workers, and development of an individual education plan (IEP) and an individual treatment plan (ITP). The IEP and ITP describe the specific educational goals and goals for improved behavior, as well as the activities and educational programs that will be used to achieve those goals.

The initial 60-day program includes a series of up to 30 intensive courses. Topics for those courses range from career awareness, assertiveness versus aggressiveness, conflict resolution, and using the library.

After the initial 60-day program, the residents participate in three basic programs.

- o Recreational - This includes group outings to community events.

- o Cottage Life - The residents live in group cottages and learn in this supervised setting to live together cooperatively.

- o Educational - All residents participate in an academic program. All residents old enough to graduate from high school (i.e. not likely to return to school after leaving Beloit) complete regular high school requirements at Beloit or take the GED test to receive a high school diploma. Only rarely does a resident in this situation leave without graduating or completing a GED. Currently two-thirds of these residents are in the GED program. A resident must be at least 16 to take the GED test, and it generally takes four to six months to prepare for the test. The education program includes a basic life skills component. Topics are individualized and can include voter registration, how to rent an apartment, and budget preparation.

All residents, regardless of age, take a career education course. All girls 16 or older also participate in vocational education. Some go to the area vocational/technical school, but most take vocational classes on the Youth Center campus. All these students take a prevocational class that stresses work ethics, dependability, accepting criticism, and other key behaviors needed for successful employment. Vocational education includes vocational classes as well as making clear the link between all educational experiences (including academic courses) and economic independence. Specific vocational courses include clerical training, nurse aide/geriatric aide training, food service training, and teacher aide training.

The Youth Center also has a work study program in which eight to ten girls usually participate. These are paid jobs in the community, such as teacher aides in elementary schools, day care providers, and nursing home aides. Several are placed through the Job Training and Partnership Act JTPA in local non-profit entities, such as aides in sheltered workshops.

All residents take a parenting education course. Generally the course lasts five to six months for about an hour every day. The course is individualized and may include the following topics: dating and marriage,

love, jealousy, family conflicts, pregnancy and baby care, and family planning. The course has several goals, including helping students to develop self-esteem, helping students understand family abuse, and teaching parenting skills that may help prevent future abuse. All students study pregnancy and baby care to help them understand the need for adequate prenatal care, what to expect from a baby, and how to handle problems without resorting to child abuse.

Alcohol And Drug Abuse Programs

Alcohol and Drug Abuse Programs are relevant to this study for two reasons. First, a recent study mentioned earlier in this report concluded that women who are divorced, separated, never-married, or unemployed are more likely than other women to abuse alcohol. 78/ Second, alcohol and drug abuse contributes to low birthweights and makes it more difficult for women who are dependent on public assistance to escape that dependency. SRS's Alcohol and Drug Abuse Services include four grant programs that provide alcohol and drug abuse services specifically for women. Those programs are described below.

The first program, in Lawrence, provides residential treatment services for up to 13 women, three of whom may also have children residing in the residential facility with them. The program provides structured living, counseling, recreational activities, and social activities. The program is designed to keep the women free of alcohol and drug abuse while learning skills that enable them to cope with their problems without returning to alcohol and drug abuse. Unemployed residents receive assistance in finding employment.

The second program, in Sedgwick County, provides outpatient (non-residential) treatment and counseling to women and children of women who have alcohol related problems. A minimum of 40 women are served each quarter. Services provided include evaluation of each women's condition and needs, education on alcohol and drug abuse, counseling, and stress management.

The third program seeks to prevent alcohol and drug abuse among a high risk group - women in prison and spouses of men in prison. The program is located in Leavenworth and provides counseling; exercise and health education; workshops on career development, parenting, and other topics; and other services. The project serves about 100 women in a one year period.

The fourth program provides services to prevent alcohol and drug abuse in Wyandotte and Johnson Counties. The services are provided to mothers and daughters who are not yet alcoholics. The services include educational activities designed to reinforce positive behavior, skill building activities that promote self-understanding, and others.

In addition to these alcohol and drug abuse programs for women, SRS funds prevention and treatment programs for youth. Concerning prevention programs, SRS funds training for teachers and school administrators who in turn set up programs in schools that provide support and counseling to help prevent alcohol and drug abuse. Concerning treatment programs, the 1985 Kansas Legislature approved $200,000 for funding the first SRS funded youth residential treatment program.

Public School Programs Relevant To Single Mothers

Public schools in Kansas provide services specifically relevant to the issues raised in this report by providing instruction in parenting skills, and providing special programs to help pregnant teenagers and teenage mothers stay in school. Although data on the extent to which Kansas schools provide parenting education are not available, the Kansas Department of Education does encourage school districts to provide parenting education. Parenting education includes information on the importance of prenatal care and parenting skills that can help prevent abuse and neglect.

Schools throughout the State provide services to help pregnant teenagers and teenage mothers stay in school, ranging from counseling to highly developed special programs. Earlier sections of this study have described the importance of education in decreasing dependence on public assistance. Following are brief descriptions of four of Kansas' most visible school programs that attempt to keep pregnant teenagers and teenage mothers in school.

- Garden City Alternative School: This year-round high school program serves school dropouts, pregnant teenagers, and teenage mothers. The school district initiated the alternative program three years ago. Presently there are 145 students enrolled. Day and night classes are available. The night classes allow working mothers to continue their education. Also, mothers can bring their children to the school building where toys and games are available for the children. Since the instruction is individualized, mothers are able to supervise their own children.

- Kansas City Alternative School: This school serves pregnant teenagers who have decided not to remain in their original school during the pregnancy. The program operates during the school year for a full day and serves 120 to 140 students in grades 7 through 12. The students are from the Wyandotte County school district and three adjacent smaller school districts. A nurse at the school monitors prenatal care and teaches a health class. This program started in 1968.

- Topeka Alternative School: This program started in 1969 and serves middle school and high school students during their pregnancies. The program operates during the school year. The regular school curriculum is provided along with classes on child development and personal development. Personal development classes are intended to build self-esteem. A social worker, psychologist, and nurse are available part-time.

- Wichita School Programs: There are six Child Learning Centers located at high schools. These are licensed day care centers which provide day care for the children of students. The day care centers are also used as instructional labs for home economic students. One of the centers is located at a vocational school which uses the center for training students in child care occupations. The school district reorganized its child care services for students in 1984. Child care services for students has been available for three years. Students pay $2.00 per day for the service and must provide transportation themselves. There is a waiting list of students needing child care. Total capacity is 160 children.

SECTION V

INITIATIVES AROUND THE COUNTRY THAT ADDRESS THE PROBLEMS OF FEMALE HEADED FAMILIES IN POVERTY

Initiatives around the country that address the problems of female headed families in poverty were researched for this study. The states contacted include those highlighted in the literature and those identified through other state and federal officials. The utility of these descriptions is that they can provide, in conjunction with the rest of this report, new concepts of how to address the issues of single mothers and poverty. Several initiatives were discussed earlier in this report and will not be included again here. Those programs include Wisconsin's child support enforcement program, California's expanded prenatal care program (OB ACCESS), and Oklahoma's requirement that Aid to Dependent Children clients with children under six must register for the Work Incentive Program.

This section summarizes initiatives in other states that focus resources on pregnant teenagers and teenage mothers, and programs that provide unusually extensive employment services. This section is not intended to discuss all such initiatives. There are undoubtedly others about which we are unaware. Also, the type of information we were able to gather about many of these programs was limited. In few cases, for example, are data on the effectiveness of these programs included.

Programs That Focus Services On Teenage Mothers

Following are descriptions of programs that focus on teenage mothers, organized by states alphabetically and followed by programs that operate in more than one state. Most of these programs use a combination of approaches, the most common of which are family planning and counseling on the benefits of delayed childbirth for teenagers who are not yet pregnant; and parenting education, family planning, prenatal care, day care, and vocational services for pregnant and parenting teenagers. In many instances, case management is provided to counsel teenagers and help them access available services. Also, in many cases services are provided in the schools to increase accessability and help keep these young women in school.

California: The State of California provides funds through their Department of Education for pregnant and parenting teenagers. Among the services provided are day care, parenting education, and career counseling. In some of these programs mothers attend an infant development class, and observe and help in the day care center. The programs, or parts of them, are funded in 165 or 16 percent of California's school districts. In 1984 the programs for parenting teenagers received $4.8 million of State money.

Illinois: The State of Illinois will spend about $11 million in fiscal year 1986 on its comprehensive Parents Too Soon initiative which began in 1983. The program seeks to reduce teenage pregnancy, reduce the health risks of teenage pregnancy, and improve teenage parents' abilities to cope with parenthood. The Governor's office coordinates the activities of ten participating agencies: Public Health, Public Aid, Children and Family Services, State Board of Education, Commerce and Community Affairs, Alcoholism

and Substance Abuse, Mental Health and Developmental Disabilities, the Planning Council on Developmental Disabilities, Employment Security, and Services for Crippled Children. The roles of the three lead agencies are discussed below.

- The Department of Health funds three demonstration projects, 20 family planning clinics, and 25 prenatal care programs for teenagers. The demonstration projects provide medical, social, and educational services in three areas of the State with high unemployment, high birthrates to teenagers, and high infant mortality.

- The Department of Public Aid has ten specialized caseworkers in Chicago who each serve about 1,000 teenage mothers each year. Caseworkers mail letters to all teenage Aid to Dependent Children clients inviting the clients to an orientation session for the voluntary program. About half those receiving letters come to the orientation session. Those who participate attend three half day workshops on self-confidence, family planning, parenting skills, and home management.

- The Department of Children and Family Services funds 28 community programs designed to prevent unwanted pregnancies and prevent neglect and abuse by teenage parents. The primary services provided by these programs are parenting classes taught in urban areas; home visitors in rural areas who teach homemaking, family planning, child care, and more; and specialized day care to help mothers complete education and training programs.

Maryland: The State of Maryland has 43 caseworkers who serve teenage parents. Referrals come from schools, health departments, and income maintenance workers. About 80 percent of the teenagers served are public assistance recipients. The caseworkers assist the teenage mothers to development a "Life Plan" that includes completion of high school, obtaining proper health care, and obtaining job training. The case managers help the teenagers access the necessary services.

Massachusetts: The State of Massachusetts spends about $2.8 million in State funds through its Department of Social Services and Community Programs for programs designed to help teenage parents become effective parents. About $1 million of the total was appropriated by the State Legislature to fund ten community programs. These ten programs provide academic training, job training, family planning, parenting education, prenatal care education, and other services. Many of the services are provided by programs located in public schools, while others are located in health clinics and neighborhood agencies.

The programs' goals are to keep teenage mothers in school, avoid subsequent unintended pregnancies, and help the teenage mothers become employed and self-sufficient. An evaluation of the original participants in the ten programs showed a small reduction in the percent of the teenage mothers receiving public assistance (53 to 46 percent), but large increases in school enrollment (40 to 74 percent), use of birth control (45 to 71 percent), job training (one to 21 percent), and employment (12 to 30 percent). About 900 clients were served in the first eighteen months of the programs.

Michigan: The Michigan Legislature provided $1 million in fiscal year 1984 and $1.7 million in fiscal year 1985 for 17 grants to community agencies that focus on preventing teenage pregnancy. The local programs provide individual and group counseling that emphasize the benefits of delaying pregnancy and childbirth. Also, ten group homes with capacity for five to eight teenage mothers are funded to provide emergency shelter for teenage mothers who have nowhere else to go.

Michigan also funds public service advertisements and documentaries on the benefits of delaying childbirth. Finally Michigan supports local communities which develop comprehensive local plans to address the issue of teenage pregnancy. To date, 26 heavily populated communities have each received $20,000 grants for this purpose.

Minnesota: The State of Minnesota has two initiatives for teenage parents. First, the Department of Public Welfare requires each county welfare department to specify how it will serve teenage parents in their social service plans. Community hospitals are required to report births to teenage mothers to these social service agencies. Caseworkers then contact the teenage mothers to offer counseling and referral to other community resources.

Second, Minnesota has a voluntary program for teenage mothers called the Minnesota Early Learning Design Program. In this program former teenage parents act as role models and provide peer counseling, and parenting and nutrition education.

New York: The State of New York has two major programs addressing teenage pregnancy. First, the Department of Social Services has funded 90 case management programs in the last five years. Currently 23 projects are funded at $1.4 million to provide support services and case management for pregnant teenagers, teenage parents, and teenagers in high risk groups for becoming pregnant. In some areas specialized public assistance case managers are utilized. Second, New York has appropriated $4.7 million to fund 30 other projects aimed at preventing initial and repeat teenage pregnancies, and to assist teenage mothers to cope effectively after having children. This second program is jointly administered by the Departments of Social Services, Children and Families, Education, and Health.

Rhode Island: The State of Rhode Island provided grants of over $300,000 total to seven programs in fiscal year 1985 to provide counseling and case management services to teenage mothers. Over 300 teenage mothers are provided services designed to keep teenage mothers in school or training programs, help teenage mothers access health care, and help teenage mothers acquire life management skills that can lead to economic self-sufficiency.

Texas: The Texas Department of Human Resources is in the planning stages of a $500,000 project that will serve about 200 teenage parents. The first two projects will be in El Paso and Houston and will provide day care, health education, vocational counseling and training, and family planning. The programs are being coordinated with the Department of Health, the Department of Education, and the Job Training and Partnership Act.

School-Based Clinics. Clinics located in school buildings have opened up around the country. For example, four high schools in St. Paul, Minnesota have health clinics located in public schools. The clinics provide a variety of health services, including sports physicals, mental health counseling, and family planning to all students. For those students with children, day care and parenting education is available. Childbearing in the St. Paul schools was reduced from about 8 per 100 to 3.5 per 100 in the first three year of the program. Drop out rates among teenage mothers declined from 45 to 10 percent.

Similar clinics exist in schools around the country. Most require parental consent for their services. An important advantage of these services is that, by providing a wide array of health services, students are able to seek family planning services without others knowing the purpose of their visit. This confidentiality increases utilization.

Paseo and Southeast High Schools in Kansas City, Missouri have clinics located in the schools. The clinics are run by the Adolescent Resources Corporation, primarily with funding from the Robert Wood Johnson Foundation. The clinics began in 1982 in the two schools that have enrollments of 1,000 at Paseo and 1,400 at Southeast.

Students receive the following services at the clinics: prenatal care services, including medical care, education, nutrition, and parenting classes; nutritional services; gynecological services, including treatment of venereal diseases and limited family planning services; and mental health counseling services. Students also receive the services of a full-time nurse practitioner, and part-time physician coverage, for all routine health care needs. The latter includes sports physicals and screenings for such conditions as high blood pressure and sickle cell anemia.

Demonstration Projects Funded By The Office Of Adolescent Pregnancy Programs: The federal Department of Health and Human Services' Office of Adolescent Pregnancy Programs has funded programs that serve pregnant teenagers, parenting teenagers, and teenagers who are at high risk of becoming pregnant. The grant programs are intended to provide health services; family planning; education and vocational counseling; life skills and parenting education; and support services such as day care. Following are descriptions of three of these programs.

- Eastern Connecticut Parent-Child Resource System, Incorporated. This private agency subcontracts with local agencies to provide services in 22 rural Connecticut towns. The 22 towns are served by two regional teams, each of which includes a program coordinator, caseworker, resource specialist, and health educator. The programs provide education to prevent teenage pregnancy, and use case management services to help teenage mothers and pregnant teenagers access needed services. Preventing subsequent unintended pregnancies is a primary goal of case management services Some money is also available to pay for educational services.

- Addison County Parent/Child Center, Middlebury, Vermont. This center provides parenting classes and counseling to pregnant teenagers, parenting teens and their extended families; day care programs in which teenage mothers work; and pregnancy prevention education programs in the schools. Caseworkers make home visits to provide advice and support, and to identify

the needs of pregnant and parenting teenagers. The center provides services, including day care, for one to three years in order to create stability and give the mother a chance to begin a career.

The Center receives about $140,000 annually and serves 150 families. The Center's services have apparently resulted in significant improvements in terms of fewer repeat pregnancies, fewer incidences of child abuse and neglect, increased education, and decreased dependence on public assistance.

- Teenage Pregnancy and Parenting Project, San Francisco. This program utilizes case managers to provide counseling and referral, and provides health and parenting classes. A special school is also available to the program's clients. An evaluation of 271 of the program's clients indicated the program was successful in decreasing the incidence of low birthweights, increasing the percentage of teenage mothers attending school, and decreasing subsequent births. 79/

Project Redirection: Starting in 1980 the Ford Foundation, the national office of the Work Incentive Program, and the Department of Labor funded four projects managed by community agencies to decrease dependency among pregnant and parenting teenagers. The projects were located in Boston, New York, Phoenix, and Riverside, California. These projects focused on helping teen-agers identify and utilize existing services. The programs provided individual counseling and matched each client with a community volunteer who counseled and supported the clients. An evaluation of the programs showed that one year after beginning in the program the clients were better off than a comparison group in terms of education, employment, and fewer subsequent pregnancies. But two years after the clients began in the program (at which time almost all clients had left the program), the clients were for the most part no better off than clients in the control group based on these measures. 80/

Employment Initiatives

Following are descriptions of innovative employment programs, starting with descriptions of several programs operating in more than one state, and followed by descriptions of programs in individual states organized alphabetically. Common elements among these programs include more extensive on-the-job training and other training opportunities than in the Kansas WIN program, and more extensive support services such as day care and transportation.

The National Supported Work Demonstration: The National Supported Work Demonstration provided twelve to eighteen months of structured employment to unemployed low-income persons in ten sites across the country. The Demonstration occurred from 1975 to 1980 and was initiated by the Department of Labor and the Ford Foundation. Supported work is different from most employment programs in three ways: peer group support, graduated stress, and close supervision. Peer group support involves placing clients in small working groups of five to ten clients. Graduated stress involves gradually increasing productivity demands as clients gain experience. Initial wages are lower to reflect the lower work standards. Close supervision is accomplished by having a program supervisor assigned to about ten clients, and having that supervisor evaluate each worker's performance frequently and communicate the assessment to the participant.

The Supported Work Demonstration targeted four groups for services: long-term Aid to Dependent Children (ADC) recipients, former drug addicts, former criminal offenders, and young school dropouts. The Demonstration's premise was that these client groups can acquire the work habits necessary for successful employment through the program. The ADC clients in the program had been on ADC at least three years and an average of nine years, 75 percent had either never worked or not worked for at least two years, and none had children under six. 81/ Local projects were operated by local, nonprofit organizations which developed work sites in settings such as construction (renovations), manufacturing, and day care centers.

The Demonstration is particularly significant because, unlike many innovative programs, the results were carefully studied. The overall project was managed by the Manpower Demonstration Research Corporation. Integral to the Demonstration was a rigorous research effort, conducted by Mathematica Policy Research, Inc. and the Institute for Research on Poverty at the University of Wisconsin. In order to assess the impact of the program on recipients, ADC clients who applied to be in the program at seven of the project sites were randomly assigned to two groups: one that received supported work and one that did not. Clients in both groups were interviewed 27 months after they began the program, which is at least a year after supported work had ended. 82/

The supported work concept turned out to be most successful for ADC clients compared to the other target groups. For the ADC clients at the time of the follow up interviews, clients who received supported work were 20 percent more likely to be employed, worked an average of 35 percent more hours per month, and had 48 percent higher earnings than the comparison clients. Although 71 percent of the supported work clients were still on ADC (compared to 85 percent in the comparison group), the average ADC and Food Stamp benefit had declined $65 per month and 42 percent of the supported work clients were employed. 83/

The research also sought to answer the question of whether the benefits of the support work program exceeded its cost. Supported work is expensive, costing about $10,624 per client. But after extrapolating the benefits of supported work over the working life of the clients, the benefits to government expenditures exceeded costs by almost half. The overall costs were computed to be $10,624 compared to $15,047 in benefits. 84/

However the benefits to government expenditures only 27 months after participation in the program began is only $3,440, considerably less than the costs. 85/ Despite this the program achieved its goal of putting ADC women to work. After paying taxes on earned income and losing ADC benefits as a result of income, the ADC clients were $1,700 better off than they would have been without the program. 86/ In sum, although expensive, small-scale supported work programs may be worthwhile in order to remove from ADC rolls long-term recipients who would otherwise be expected to remain on ADC for many years.

Grant Diversion: Grant diversion is a means to help finance supported work or other types of on-the-job training. Grant diversion has been an option since the federal budget act of 1981. Grant diversion works in the following way:

- o The client is placed in an entry level job in private industry, usually in clerical or maintenance occupations.

- o The client's ADC grant is reduced, as it normally would be, to reflect the earned income.

- o For a specified period of time the amount of reduced ADC grant is placed in a pool used to subsidize employers who provide on-the-job training.

Grant diversion is being used by some states to fund on-the-job training programs. An initial evaluation of experience in six states has been done. The states involved are Arizona, Florida, Maine, New Jersey, Texas, and Vermont. The study reveals several problems. First, it is difficult to find employers willing to provide enough on-the-job training slots. Second, grant diversion has not provided enough money to fully fund the programs. And third, the program is administratively complex and costly. Nevertheless, if Kansas chooses to develop a supported work program for long-term ADC clients, grant diversion should be considered as a funding source. 87/

America Works: America Works is a private-for-profit corporation that contracts with several states (Connecticut, Ohio, and Massachusetts) to run employment programs for ADC clients. America Works functions in the following way:

- o Clients receive a two-week orientation that includes basic work skills such as punctuality and appearance; identification of job goals; encouragement and motivational exercises; and identification of needs such as transportation and child care.

- o Clients receive specific job training for up to six weeks, usually focusing on clerical skills.

- o Clients are placed in private companies. America Works subsidizes employment for three or four months, and provides supervision of clients in a way similar to the supported work program.

America Works also assists clients with child care and transportation when necessary. America Works offers employers trained, recruited, entry-level employees with subsidized wages. The states pay America Works and pays for some of the support services, such as day care. Grant diversion is used to pay part of the costs. The primary advantage to the states is that America Works develops the job opportunities.

Although America Works' programs have not been thoroughly studied, it appears to be a very expensive but potentially effective means of decreasing welfare dependency. As an option it appears states could implement the America Works' concepts through state staff or contracts with local non-profit organizations.

Iowa: The State of Iowa spends about $2 million to provide vocational training to about 3,400 public assistance clients, 90 percent of whom are single mothers. Most participants have a high school education and attend community colleges for licensed practical nurse or clerical training. The average length of participation is 14 months. The state pays for tuition,

fees, books, supplies, child care, and $60 per month for transportation. Participants must apply for financial aid and low interest loans.

Although probably only appropriate for higher functioning ADC clients, the program has the benefit of preparing ADC clients for jobs that can potentially raise them above the poverty level. Iowa officials estimate the long-term benefits exceed costs by two to one.

Massachusetts: Massachusetts has an unusually extensive array of services for its Aid to Dependent Children/Work Incentive Program clients. The program, called CHOICES, is also distinctive in that it recruits volunteers among normally exempt women with children under six. About 20 percent of the participants are now WIN exempt clients.

The services offered are different from Kansas in two ways. First, higher education, supported work operated by community agencies, and vocational education are provided to 23 percent of the clients. These services, that have potential for allowing clients to get higher level jobs that will pull them out of poverty, are not available in Kansas' WIN program. Massachusetts officials report higher job placement and retention rates than in their previous WIN program. The second difference is that the CHOICES program includes extensive day care and transportation assistance.

The volunteer rate and waiting lists indicate that single mothers who are dependent on public assistance will choose to work if a viable alternative, including day care and support, is made available to them.

Texas: The State of Texas' WIN program contracts in parts of the State with private organizations that attempt to place clients in jobs. For example, the State pays $100 for a job preparation class if the services result in five job leads. If the person becomes employed, the State pays $4.50 for each day the person is employed up to 90 days. Texas officials report participants had a higher job placement rate than WIN clients receiving regular WIN placement services.

Utah: The State of Utah has a voluntary self-sufficiency program for WIN registrants. About half of Utah's ADC clients are voluntary participants in the program. Specialized caseworkers develop self-sufficiency plans and conduct workshops in assertiveness, self-esteem, and job seeking. This part of the program operates much like the classroom portion of Kansas' Job Club, but is provided to a larger percentage of clients. Child care is provided to participants when needed and extends for four months after clients get a job.

SECTION VI

COST EFFECTIVE STRATEGIES FOR DECREASING DEPENDENCE ON PUBLIC ASSISTANCE AMONG SINGLE MOTHERS, AND AMELIORATING THE EFFECTS OF THEIR POVERTY

This report cannot provide the information needed to solve the immense problems of poor female headed families. The roots of those problems rest largely in national economic and social patterns that are far beyond the ability of any state agency to address. SRS also recognizes that resources for new or enhanced programs are scarce. But we believe we must begin to make the investment necessary to help reduce future dependence on public assistance, child abuse and neglect, and other problems associated with poverty.

Following are four strategies that could be pursued that have the potential to have a significant impact on the problems of poor single mothers, and that are possible to operate at modest levels with moderate costs.

- Provide special employment programs for Aid to Dependent Children mothers of children under six, and provide the day care and other support services needed for these women to successfully participate.

- Expand the number of poor pregnant women who receive prenatal care and expand the number of children who receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Included in this strategy should be the expansion of the Medicaid Ribicoff rules to include children from 5 to 21 years old.

- Provide services to Aid to Dependent Children clients and other high risk groups designed to prevent child abuse and neglect.

- Develop programs in conjunction with the Department of Health and Environment, and the Department of Education, to help prevent unintended pregnancy, and provide services to help teenage mothers avoid dependence on public assistance. These programs should include.

  - Increased accessibility to Medicaid family planning services.

  - School-based health clinics that make prenatal care, family planning, and general health services more accessible to low-income teenagers.

  - Specialized caseworkers for teenage mothers on public assistance to help them access services and plan for their future.

Each of these strategies, and a specific implementation proposal for each, is discussed below. The specific implementation proposals are intended to clarify how these programs could work, but these are not the only workable approaches.

Provide Special Employment Programs For Aid To Dependent Children Mothers Of Children Under Six, And Provide Day Care And Other Support Services Needed For These Women To Successfully Participate

Background

In Kansas 65 to 70 percent of single mothers on ADC are exempt from the WIN program because they have children under six. Although some volunteer for the program, SRS does not make a concerted effort to encourage them to volunteer, largely because the day care funds needed to make their participation feasible does not exist. Yet studies discussed earlier in this report have shown that mothers of children under six are able and willing to work if provided with appropriate services.

Despite their being ignored by employment programs, the previously cited Harvard study found that of the women who left ADC through work, 67 percent were mothers of children under six. In other words, the women with the greatest potential for getting jobs are being systematically left out of SRS' employment programs. Many believe it is more difficult for women to get jobs after they have been out of the job market for longer periods. If this is so, we reduce the changes of success by not offering employment programs to younger mothers. Even women who want to stay at home with their young children would have a better chance of becoming employed later if they had employment training during their children's early years.

Some states have required younger ADC mothers to register for WIN. Other states have successfully marketed the WIN program and seen large numbers of volunteers among younger mothers. In either case, involving younger mothers is not possible without additional funding for day care, transportation, and other support services.

Program Proposal

There are many possible and worthwhile approaches to expanding employment services for public assistance mothers of young children. The proposal discussed here involves the following elements.

- Select one urban area as a pilot test site.
- Provide employment services annually to 100 mothers whose youngest children are between three and six years old. These 100 mothers would be volunteers recruited for the program.
- The following services would be provided.
  - Each mother would be interviewed to assess employment interests and services needed for each mother to succeed.
  - About half (50) of the mothers would receive training for a high school equivalency test (GED).
  - Almost half (40) of the mothers would receive two semesters of vocational training.

- About half (50) of the mothers would receive the assistance of a Job Club to fund employment.

o Day care, transportation assistance, and money for job related expenses would be provided to all mothers who need them.

Operating such a program would require two professional staff persons to recruit clients, conduct interviews, arrange services, and do follow-up work with clients. The costs for this program would be about $110,000 annually, including expenses for the two staff persons, the employment services (including additional Job Club staff), day care, and transportation. Unless the program was able to utilize federal WIN funding, the time consuming WIN registration processes could be simplified to allow the use of more resources for services to clients. The steps involved in developing such a program include:

o Select a test site.

o Develop more detailed descriptions of services to be provided, including descriptions of how and where employment and day care services will be provided.

o Seek and apply for public and private grant funds to operate the pilot program.

o Arrange the administrative mechanisms to pay or contract for the staff and to pay for purchased services.

o Hire, or contract for, and train the program staff.

Beyond special employment programs for mothers of younger children, another strategy that should be pursued is to expand employment programs for ADC parents of children of all ages, especially long-term ADC clients. Programs that offer supported work and vocational education are expensive, but are the only way to effectively help certain types of ADC clients to leave ADC. Such programs may be affordable on a small scale. Expanding jobs programs will be most effective if accompanied by expanded support services, such as day care, and extended medical benefits for a period after jobs are obtained.

Expand The Number Of Low-Income Pregnant Women Who Receive Prenatal Care, And Expand The Number Of Children Who Receive Early And Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Background

Low birthweight infants are a serious and costly public health problem that is directly linked to poverty and inadequate prenatal care. Low birthweights are a more serious problem in Kansas than in the rest of the country as a whole. In addition, this study showed Medicaid clients are more likely to have low birthweight infants and less likely to get adequate prenatal care than women in the general population. In response SRS should pursue initiatives to promote and expand prenatal care services for Medicaid clients.

Early and Periodic Screening, Diagnosis, and Treatment services are considered to be a cost effective preventive health service for children. Yet less than half of eligible ADC clients use the service. Expanded outreach to encourage Medicaid clients to use this service is an option that should be pursued. Also policies that make additional poor children eligible to receive Medical Assistance (EPSDT) should be pursued to limit the number of children in Kansas without access to primary health care.

Program Proposals

Three proposals are made here to address these issues. First, to pursue the already begun initiative to encourage the use of prenatal care by paying for Medical Assistance clients to take prenatal risk reduction classes. Second, to expand our outreach efforts to encourage eligible Medical Assistance clients to use EPSDT services. Third, to expand Medicaid eligibility to include Ribicoff children from ages 5 to 21.

Prenatal Risk Reduction Classes. One reason low-income women do not receive adequate prenatal care is that they are not aware of its availability and benefits. SRS's current budget proposals for fiscal year 1987 propose to address this problem by including prenatal risk reduction classes as a reimbursable service in the Medicaid and MediKan programs. These classes will be offered by local health departments. The classes will focus on the need for prenatal care; and the importance of avoiding alcohol, smoking, and other dangers to the pregnancy. In order to encourage clients to take these classes, it may be necessary to add an outreach component to the program, including the use of paraprofessionals as in the EPSDT effort described below.

The steps required to implement this proposal include budgeting for the cost of the classes and working with the Department of Health and Environment to ensure the classes are available. These steps have already begun.

Increase Provider Reimbursement For Prenatal Care. Another problem that can limit the ability of Medicaid clients to get prenatal care is difficulty in finding providers who accept Medicaid clients. This can be a particular problem in rural areas of the State. Clients in those areas do report difficulty in finding Medicaid providers. Low reimbursement levels is sometimes cited by providers as their reason for limiting the number of Medicaid clients they see. One way to alleviate this problem is to increase reimbursement rates, particularly for services, such as prenatal care, that are critically important and cost effective to have available to Medicaid clients.

The current maximum reimbursement of $111 for prenatal care is 56 percent of the regular fee ($200) charged by Medicaid providers at the 75th percentile (i.e. 75 percent charge less than $200 and 25 percent charge more than their private pay patients.) SRS should consider raising its reimbursement rate to 100 percent of the regular fee at the 75th percentile to help ensure the availability of prenatal care providers throughout the State. This increase would cost between $400,000 and $500,000.

EPSDT Outreach. Currently all Medical Assistance applicants are told of the availability of EPSDT services. Clients are given a form they can return to the SRS office to request EPSDT services. They are also given an EPSDT brochure. If they do return the form, the local SRS office may provide the

client with the name of a provider or may go as far as to schedule an appointment with the provider. Medical Assistance also spends about $50,000 annually to reimburse clients for mileage to drive to EPSDT services. Despite this process, as mentioned earlier less than half of ADC eligible clients use EPSDT services. Part of the reason for the limited success of this outreach effort is probably that the referrals are made at the time clients apply for benefits. They may not know at that time whether or not they will be eligible for EPSDT, and at that point in the process they may be more concerned about their eligibility determination than the possibility of receiving preventive health services (EPSDT).

To increase the success of EPSDT outreach, SRS should initiate a pilot project that utilizes paraprofessionals to expand the outreach effort. This outreach effort could also be used to encourage the utilization of newborn home visits. This is a service that began recently to be covered by Medical Assistance and involves a home visit by a nurse to check infants for medical problems. This outreach proposal involves the following elements.

- Select one area as a pilot test site.
- Utilize one or two paraprofessionals to do the following outreach efforts.
  - Meet face-to-face with clients in SRS offices to discuss EPSDT and encourage clients to use the service. These contacts would be in addition to the EPSDT referral made at the time of application.
  - Contact clients by phone and in their homes to discuss the benefits of EPSDT for clients who have not used the benefits, and to encourage clients who have used EPSDT benefits to continue to do so.
  - Offer transportation assistance to clients who cannot get to EPSDT services.
  - Develop public relations tools (posters, flyers, and etcetera) to inform persons, who do not receive personal contact, about EPSDT.
- Central SRS personnel would continue their efforts to inform primary physicians in the Primary Care Network program of their contractual agreement to promote and provide EPSDT services.

Operating such a program would require one or two paraprofessional staff, and funds for the staffs' travel. One option would be to train and utilize Aid to Dependent Children clients to be paid as paraprofessional outreach workers. Workers doing this outreach could also do the family planning outreach described in a previous section. The cost would be about $30,000. The steps involved in developing such a program include:

- Select a test site.
- Develop more detailed descriptions of the services to be provided.
- Develop a plan for evaluating the success of the pilot program.

- Seek and apply for public and private grant funds to operate the pilot program.
- Arrange the administrative mechanisms to pay or contract for the staff and pay for travel costs.
- Hire, or contract for, and train the program staff.

Expand Ribicoff Children. As described earlier in this report, Kansas has chosen to provide "Ribicoff" coverage only to children under five years old born after October 1983. These are children who would be eligible for Medicaid under normal rules based on income, but live in households not deprived of parental support as defined by Aid to Dependent Children rules. Many of these children would have been eligible for the State funded MediKan program even without Ribicoff. Since the State gets federal financial participation for those clients when they enter the Medicaid program that they would not get without Ribicoff, the State actually saves money for these Ribicoff children. These savings offset some or all the costs of the Ribicoff children who would not have been eligible for Medicaid or MediKan in the absence of the Ribicoff rule.

If Kansas expanded Ribicoff coverage to all children under 21 years old, we estimate 450 additional children would be served. The costs of serving these new children would be at least partially offset by the shifting of a larger number of children from MediKan to Medicaid that would occur if Ribicoff were expanded. The primary step required to implement this regulation is to promulgate new regulations to expand the ages covered by the Ribicoff rule.

Provide Services To Aid To Dependent Children Clients And Other High Risk Groups Designed To Prevent Child Abuse And Neglect

Background

SRS is currently studying its Family Services Program to assess its effectiveness in preventing child abuse and neglect. Most of those services are directed at clients who have already abused or neglected their children or are found very likely to do so in the near future. One option is to invest more funds in services designed to prevent abuse and neglect among parents who are considered high risk, by some criteria, but have not yet been reported to SRS as having abused or neglected their children.

One logical target for such preventive services would be Aid to Dependent Children clients. In Kansas, in the first half of fiscal year 1985, 35 percent of all families that had reports of abuse or neglect on them were public assistance recipients. Of all families that had reports of abuse or neglect and received family support services in fiscal year 1984, generally the more severe cases, almost 60 percent were public assistance recipients. It would be more humane and less costly to prevent the initial abuse or neglect than to work with the family after the problem reaches a crisis situation.

Program Proposals

As with the employment programs, there are unlimited variations of services that could be effectively provided. This particular proposal includes the following elements:

- o Select one SRS area office as a test site.

- o Provide child development and life management classes to 450 parents annually. Clients would be referred to the service by income maintenance workers. Project staff would also recruit clients among public assistance recipients. Three classes of 15 people would be taught in each five-week span. Classes would involve ten class meetings lasting 2 1/2 hours. Child care during the class meetings and transportation assistance would be provided. Classes would focus on budget preparation, child development, and specific techniques for parents to use in nurturing and disciplining their children.

- o Provide peer support group meetings, led by a professional, to 150 parents annually. The parents needing this additional help would be recruited primarily from the parenting education classes. Peer support groups of 15 mothers would meet for 1 1/2 hours once a week for ten weeks. Two peer support groups would run simultaneously. Child care and transportation assistance would be provided. Peer support groups provide mothers an outlet for their frustrations and a forum to share ideas and coping strategies.

- o Provide in-home family services and respite child care to 90 clients per year who have been identified in the classes as very high risk clients for abuse or neglect. Three paraprofessionals would do this in-home work. They would have caseloads of about 10 clients. Those caseloads would turn over about three times per year. The reason for these low caseloads is that family support workers typically spend several hours each week with each client for an extended number of weeks. During that time the family support worker works with the family during their regular daily routine to offer support and guidance in parenting techniques, household management, and child development. The family support worker acts as a role model, a process which takes a great deal of time.

Operating such a program would require two professional staff to recruit clients, and operate the parenting classes and peer support groups. Three paraprofessionals would be needed to provide in-home services. The costs for this program would be about $80,000 for staff, travel for home visitors, and child care and transportation assistance for child development and life management classes and peer support groups. The steps involved in developing such a program include:

- o Select a test site.

- o Develop more detailed descriptions of services to be provided, including the specific parenting education curriculum to be used, the types of activities to pursued in the peer group sessions, and the types of in-home services to be provided. It may be necessary to develop

different approaches for different clients, such as mothers of older versus younger children, and mothers who may abuse their children versus women who may neglect their children. Work with local health departments and other community groups to develop the complete package.

- o Arrange for space for classes and group meetings in or near the SRS office(s).
- o Develop a plan for evaluating the success of the pilot program.
- o Seek and apply for public and private grant funds to operate the pilot program.
- o Arrange the administrative mechanisms to pay or contract for the staff and pay for purchased services.
- o Hire, or contract for, and train the program staff. Extensive training may be needed if qualified parenting educators cannot be found. If so, these training costs would have to be added to the program's budget.

Develop Programs In Conjunction With The Department Of Health And Environment And The Department Of Education To Help Prevent Unintended Pregnancies, And Provide Services To Help Teenage Mothers Avoid Dependence On Public Assistance

Background

Data from national studies and this study's survey of Aid to Dependent Children (ADC) clients indicate helping to reduce unintended pregnancies is the most significant single step that can be taken to reduce poverty in this group. For example, a 1983 study by two Harvard researchers found that women with just one child are twice as likely to leave public assistance by getting jobs than women with three children. And, this SRS study's survey of Kansas ADC clients showed that having fewer children was associated with shorter stays on ADC, shorter amounts of time since having a job, higher education levels, and less difficulty getting day care.

Not only does having additional children make it more difficult for women to become educated and to work their way out of poverty, it deepens the level of their poverty. Women with more children must divide their limited income among more children, making it both more difficult to live decently and more difficult to take the steps needed to get a job.

Unintended pregnancies among teenagers is of particular concern for two reasons. First, the proportion of births to teenagers that are to unmarried teenagers is growing and is almost 40 percent in Kansas. Second, teenage mothers are more likely to have more children, are less likely to complete their education, are more likely to be unemployed, and are more likely to be in poverty and on public assistance than women who delay childbirth.

Program Proposals

To address the issue of reducing unintended pregnancies, especially unintended teenage pregnancies, three approaches are proposed. First, only

about 10 percent of female Medicaid clients between 15 and 30 years old use family planning services provided by Medicaid. To increase this percentage, those services should be made more accessible. Second, to reduce unintended pregnancies and increase access to health care for low-income teenagers, SRS should help establish clinics in certain schools. Third, to increase the chances of teenage mothers leaving public assistance, SRS should provide specialized caseworkers to help teenage mothers access services and plan for the future. Specific approaches for these proposals are discussed below.

Increase Access To Family Planning. Aid to Dependent Children applicants are informed of the availability of family planning as part of their medical services and are told where they can get family planning services. To increase utilization of these services this proposal includes the following elements to expand this outreach effort.

- o Select a pilot test site.
- o Work with the Department of Health and Environment, local health departments, and other providers to make the one-on-one counseling and education portion of family planning available in the SRS office on a walk-in basis. The experience with school based clinics shows that making health services accessible to low-income persons can dramatically increase their utilization. In a pilot program one half-time nurse would probably be adequate for this portion of the program. In this proposal the medical portion of family planning (examinations, laboratory, and etcetera) would be done by the regular providers at the regular location, but would be supplemented by the following outreach effort.
- o Utilize one or two professionals to do the following outreach efforts.
  - Meet face-to-face with clients in SRS offices to discuss the benefits and availability of family planning services. These contacts would be in addition to the family planning referral made at the time of application.
  - Contact clients by phone and in their homes to make them aware of family planning services.
  - Offer transportation assistance to clients who cannot get to family planning services.
  - Develop public relations tools (posters, flyers, and etcetera) to inform persons, who do not receive personal contact, about family planning services.

One option would be to train and utilize Aid to Dependent Children clients to be paid as paraprofessional outreach workers. Workers doing this outreach could also do the EPSDT outreach described in a later section. The cost of such a program would be between $40,000 and $50,000. That cost would include the part-time nurse, and funds for two paraprofessional staff and their travel. The steps involved in developing such a program include:

- Meet with the Department of Health and Environment and local health departments to seek support and agree on shared responsibilities.

- Select a test site.

- Develop more detailed descriptions of the services to be provided.

- Develop a plan for evaluating the success of the pilot program.

- Seek and apply for public and private grant funds to operate the pilot program.

- Arrange the administrative mechanisms to pay or contract for the staff and pay for travel costs.

- Hire, or contract for, and train the program staff.

Help Establish School-Based Clinics. School-based clinics are being used around the country including Kansas City, Missouri to improve health care and prevent unintended pregnancies in areas where rates of teenage childbirth and low birthweight infants are high. This proposal is to work with the Department of Health and Environment and the Department of Education to develop at least one such clinic initially in an urban county. Wyandotte County, for example, exceeds Kansas and national norms in the areas of adolescent parenthood, out of wedlock births, single headed families, the percentage of families below poverty, the rate of low birthweight infants, and the rate of infant mortality. Specifically this proposal includes the following elements:

- Provide over 2,000 medical and medically related services to students in one senior high school annually.

- Students would receive the services of a full-time nurse practitioner, and part-time physician, for all routine health care needs. The latter includes sports physicals and screenings for such conditions as high blood pressure and sickle cell anemia. Students would also be able to receive the following services at the clinic: prenatal care services, including medical care, education, nutrition, and parenting classes; nutritional services; substance abuse prevention and treatment services; gynecological services, including treatment of venereal diseases and limited family planning services; and mental health counseling services.

- The staff for such a clinic would include:

  - One physician eight hours per week.
  - One full-time nurse practitioner.
  - One full-time medical assistant.
  - One full-time social worker.
  - One nutritionist four hours per week.
  - One substance abuse counselor one day per week.

Assuming that space could be provided by the school, the costs for the clinic, including staff and medical supplies, would be about $160,000 annually. Arrangements would need to be made, probably through the county health department, for 24-hour backup medical coverage. This would be needed

in order for the clinic to be reimbursed by Medicaid for its services because the Medicaid Primary Care Network program requires that all services be approved or provided by an assigned primary care physician. That physician or physician group must be available 24-hours a day. Since needing referrals to the clinic would limit its accessibility and effectiveness, the clinic would have to be considered a primary care physician in the Primary Care Network program so that referrals to the clinic would not be necessary.

Potential funding sources for such a clinic include:

- o Private or public grants.
- o Federal Maternal and Infant Care funds through the Department of Health and Environment.
- o Medicaid for services provided to Medicaid clients in the clinic that are Medicaid-covered services.
- o Federal or state alcohol and drug grant funds through SRS.

The steps involved in developing such a program include:

- o Meet with the Department of Health and Environment and the Department of Education to seek support, agree on shared responsibilities, more clearly define the services to be offered by the clinic, and to discuss funding options.
- o Work with the other State Departments, local school districts, local health departments, and other local organizations to select a site for the clinic. The clinic should be in an area where local support for the project is strong and the need is great.
- o Develop a plan for evaluating the success of the clinic.
- o Arrange the administrative mechanisms to reimburse the clinics, when appropriate, through Medicaid.
- o Work as needed with involved State and local agencies to seek funding, hire staff, and train staff.

Provide Specialized Caseworkers. Specialized caseworkers have been used in other states to provide the additional guidance and support needed by pregnant or parenting teenage public assistance clients to access needed services and make plans to become self supporting. This proposal for specialized caseworkers involves the following elements.

- o Select one urban area as a pilot test site.
- o Provide case management services to 300 pregnant or parenting teenage public assistance clients annually. Each of three caseworkers would have a caseload of about 20. Those caseloads would turn over about five times per year.
- o The caseworkers would provide the following services.

- Meet with the client to help the client develop a long-term life plan including goals for education and employment.

- In the short-term, assist the client in accessing services needed to achieve those goals, including prenatal care, infant care, family planning, child care to enable the mother to stay in school, employment programs, and others.

Operating such a program would require one professional and two paraprofessional staff members. The costs for this program would be about $55,000, including expenses for staff and travel costs for the staff. The steps involved in developing such a program include:

- o Select a test site.

- o Develop more detailed descriptions of services to be provided, including the type of counseling to be offered and the services to which clients will be referred.

- o Develop a plan for evaluating the success of the pilot program.

- o Seek and apply for public and private grant funds to operate the pilot program.

- o Arrange the administrative mechanisms to pay or contract for the staff.

- o Hire, or contract for, and train the program staff.

Another option is to rearrange caseloads among current income maintenance staff so that some income maintenance workers specialize in cases involving teenage mothers. These workers would have to have lower caseloads in order to have time to provide the necessary counseling and support. In most areas of the state these lower caseloads would not be possible without providing additional staff.

Other Options

The strategies discussed above are not the only options available to help low-income single mothers. They were selected for their high potential effectiveness with small investments. Following are some other options that could be considered.

- o **Increase ADC Benefit Levels.** Regardless of what we do, there will continue to be poor women and children on public assistance. Benefit levels have not kept pace with inflation and are well below both the federal poverty level and the Kansas Legislature's definition of minimum need.

- o **Continue To Expand The Child Support Enforcement Program.** Helping women to receive reasonable child support payments from absent parents is a cost effective way to reduce poverty and public assistance. Although recent changes have expanded the Kansas Child Support Enforcement program, further steps could be taken to increase the number of women regularly receiving child support payments.

APPENDIX I

Footnotes

Footnotes

Note: Information from Kansas State Government documents are not footnoted. The sources for those data can be had by calling the Office of Analysis, Planning, and Evaluation.

1/ Judith Cummings, "Breakup of Black Family Imperils Gains of Decades" (National Forum for Black Public Administrators, 1984), p. 2.

2/ United States Census, General Social and Economic Characteristics - Kansas, 1980, Table 72.

3/ United States Census, General Social and Economic Characteristics - Kansas, 1970, Table 58.

4/ Cummings, p. 2.

5/ United States Census, Statistical Abstract of the United States, 1985, p. 64.

6/ United States Department of Health and Human Services, Public Health Service, Better Health For Our Children: A National Strategy, (Washington, Government Printing Office), p. 5.

7/ Cummings, p. 3.

8/ U.S. Congressional Budget Office, Poverty Among Children, December 3, 1984, figure 11.

9/ Ibid., p. 5.

10/ Ibid., p. 12.

11/ U.S. Congress, House Select Committee on Children, Youth, and Families, Children, Youth, and Families: Beginning The Assessment, Hearing, 98th Congress, 1st Session, April 28, 1983, (Washington, Government Printing Office, 1983), p. 20. (From testimony by Alice M. Rivlin, Director, Congressional Budget Office.)

12/ United States Census, General Social and Economic Characteristics - Kansas, 1980, Table 72.

13/ United States Census, A Statistical Abstract Supplement, 1980, p. 507.

14/ Greg J. Duncan, Years of Poverty/Years of Plenty, 1984, (Ann Arbor, Michigan, The University of Michigan Institute for Social Research, 1984), p. V.

15/ Ibid., p. 3.

16/ Ibid., p. 41.

17/ Ibid., p. 48.

18/ Ibid., p. 49.

19/ Ibid., p. 64.

20/ Joan L. Wills, Barbara Beiler, and Martha Warren, Working Paper on Women and the Economy, July 1984, The National Governors' Association Center for Policy Research, pp. 6-7.

21/ Ruth Sanders, Bureau of the Census, Child Support and Alimony: 1981 (Washington, Government Printing Office, May 1983), p. 1.

22/ U.S. Congress, House Subcommittee on Human Resources of the Committee on Education and Labor, Hearing on Child Care Information and Referral Services Act, Hearing, 98th Congress, 1st Session, September 15, 1983, (Washington, Government Printing Office, 1984), p. 154. (From testimony by Therese W. Lansburgh, Chair, Maryland Committee for Children.)

23/ U.S. Congress, House Subcommittee on Elementary, Secondary, and Vocational Education of the Committee on Education and Labor, School Facilities Child Care Act, Hearing, 98th Congress, 2nd Session, April 30, 1984, (Washington, Government Printing Office, 1984), p. 38. (From testimony by Helen Blank, Director, Child Care and Family Support Services, Children's Defense Fund.)

24/ Mary Jo Bane and David T. Ellwood, The Dynamics of Dependence: The Routes to Self-Sufficiency, June 1983, (Cambridge, Massachusetts, Urban Systems Research and Engineering, Inc., June 1983), p. 5.

25/ Ibid., p. V.

26/ Ibid., p. 44.

27/ Kristin A. Moore and Martha R. Burt, Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing, 1982, (Washington, D.C., Urban Institute Press, 1982), pp. 9-10.

28/ Ibid., pp. 13-14.

29/ Ibid., pp. 9-14.

30/ Kristin A. Moore and Richard F. Wertheimer, "Teenage Childbearing and Welfare: Preventive and Ameliorative Strategies," Family Planning Perspectives, Volume 16, Number 6, (November/December, 1984) p. 285.

31/ Children's Defense Fund, Preventing Children Having Children, 1985, (Washington, D.C., Children's Defense Fund, 1985), p. 14.

32/ Ibid.

33/ Kristin A. Moore, Social and Economic Consequences of Teenage Childbearing for Women, Families, and Government Welfare Expenditures, Testimony to the Human Resources Committee of the United States Senate, June 14, 1978, (Washington, D.C., Urban Institute, 1978), p. 16.

34/ United States Census, Detailed Population Characteristics - Kansas, 1980, Table 247.

35/ Russell W. Rumberger, "Dropping Out of High School: The Influence of Race, Sex, and Family Background," American Educational Research Journal, Summer 1983, Volume 20, Number 2, p. 201.

36/ Frank L. Mott and Nan L. Maxwell, "School-Age Mothers: 1968 and 1979," Family Planning Perspectives, Volume 13, Number 6, November/December 1981, p. 288.

37/ Frank Furstenberg, Jr., Unplanned Parenthood: The Social Consequences of Teenage Childbearing, 1976, (New York, Free Press, 1976).

38/ Mott and Maxwell, 1981, p. 291.

39/ Furstenberg, 1976.

40/ Moore, 1978, pp. 1-2.

41/ Ibid., p. 10.

42/ Kristin A. Moore and Richard F. Wertheimer, Teenage Childbearing: Public Sector Costs, December 1982, (Washington, D.C., The Urban Institute, 1982), p. 9.

43/ Moore, 1978, p. 13.

44/ Moore and Wertheimer, 1982, p. 10.

45/ Ibid., p. 16.

46/ Ibid., p. 18.

47/ Ibid., p. 24.

48/ Ibid., pp. 186-187.

49/ U.S. Public Health Service, "Women's Health: Report of the Force on Women's Health Issues," Public Health Reports, January-February 1985, Volume 100, Number 1.

50/ Institute of Medicine, National Academy of Sciences, Preventing Low Birthweight: Summary, 1985, (Washington, D.C., National Academy Press, 1985), p. 3.

51/ Ibid.

52/ "Infant Mortality Lowest Yet In The U.S.," Perspective, Winter 1984, p. 20.

53/ William H. Topper, "Importance of Preventative Medical Services," Children's Coalition White Paper: Prenatal and Infant Care, (Children's Coalition, Topeka, 1985), p. 12.

54/ Institute of Medicine, 1985, pp. 3-4.

55/ William H. Topper, 1985, p. 12.

56/ Institute of Medicine, 1985, p. 3.

57/ U.S. Division of Maternal and Child Health, Department of Health and Human Services, Vital Statistics, 1982.

58/ United States Census, A Statistical Abstract Supplement, 1980, p. 451.

59/ Institute of Medicine, 1985, pp. 2-3.

60/ A Fiscal Imperative: Prenatal and Infant Care, February 24, 1985, Southern Regional Task Force on Infant Mortality (State of South Carolina, Office of the Governor, 1985), p. 10.

61/ Institute of Medicine, 1985, p. 4.

62/ Ibid., pp. 7-9.

63/ U.S. National Center for Health Statistics, Department of Health and Human Services, "Trends In Teenage Childbearing: United States 1970-1981," Vital and Health Statistics, Series 21, Number 41, p. 11.

64/ Maridee Gregory, Final Evaluation of the Obstetrical Access Pilot Project, December 1984, (Sacramento, Department of Health Services, 1984), p. viii.

65/ Institute of Medicine, 1985, p. 22.

66/ Rita Kay Ryan, "Maternal Demographics, Prenatal Care Adequacy, and Pregnancy Outcomes in Kansas, 1980-1982, Basis for Program Development and Client Education" (Ph.D. dissertation, Kansas State University, 1984), p. 32.

67/ Ibid., p. 40.

68/ Ibid., p. 42.

69/ James Garbarino, "What Have We Learned About Child Maltreatment?," Perspectives on Child Maltreatment in the Mid '80s, Office of Human Development Services, National Center on Child Abuse and Neglect, p. 7.

70/ Office of Human Development Services, Department of Health and Human Services, Executive Summary: National Study of the Incidence and Severity of Child Abuse and Neglect, 1981, p. 10.

71/ Frederick D. Herzon and Michael Hooper, Introduction to Statistics for the Social Sciences, (New York, Thomas Y. Crowell Company, 1976), p. 368.

72/ Sharon C. Wilsnack, Richard W. Wilsnack, and Albert D. Klassen, "Drinking and Drinking Problems Among Women in a U.S. National Survey," Alcohol World: Health and Research, Winter 1984/1985, Volume 9, Number 2, p. 11.

73/ Marcia Guttentag and Susan Salasin, "High Risk Groups for Depression," Women's Worlds: NIMH Supported Research On Women, National Institute of Mental Health (Washington, U.S. Government Printing Office, 1978), p. 65.

74/ United States Census, Statistical Abstract of the United States, 1985, p. 65.

75/ Bane and Ellwood, 1983, p. IV.

76/ Ibid., p. II.

77/ Office of Human Development Services, Department of Health and Human Services, Executive Summary: National Study of the Incidence and Severity of Child Abuse and Neglect, 1981, p. 10.

78/ Wilsnack, Wilsnack, and Klassen, 1985, p. 11.

79/ Center for Population and Reproductive Health, University of California, San Francisco, Evaluation of the Teenage Pregnancy and Parenting (TAPP) Project, 1985.

80/ Janet C. Quint and James A. Riccio, The Challenge of Serving Pregnant and Parenting Teens: Lessons From Project Redirection, (New York, Manpower Demonstration Research Corporation, 1985).

81/ Stanley H. Masters, The Institute for Research on Poverty, University of Wisconsin, and Rebecca Maynard, Mathematica Policy Research, Inc., The Impact of Support Work On Long-Term Recipients of AFDC Benefits, (New York, Manpower Demonstration Research Corporation, 1981), p. vii.

82/ Ibid., pp. 19-21.

83/ The Board of Directors, Manpower Demonstration Research Corporation, Summary and Findings of the National Supported Work Demonstration, (Cambridge, Massachusetts, Ballinger Publishing Co., 1980), pp. 59-61 and 68-69.

84/ Peter Kemper, David A. Long, and Craig Thornton, Mathematica Policy Research, Inc., The Supported Work Evaluation: Final Benefit-Cost Analysis, (New York, Manpower Demonstration Research Corporation, 1981), p. 106.

85/ Ibid., p. 100.

86/ Ibid., p. 101.

87/ Michael Bangser, James Healy, and Robert Ivry, Welfare Grant Diversion: Early Observations From Programs in Six States, (New York, Manpower Demonstration Research Corporation, 1985).

APPENDIX II

Survey Form For Survey Of Kansas Aid To Dependent Children Clients

Dear SRS Client:

Please answer the questions below. The answers will be used to help improve SRS services. This survey is voluntary and will not affect your eligibility or benefits.

Answer each question. Then mail the answers back in the enclosed envelope within five days. No stamps are needed. If you have your children and grandchildren living with you, check here ___, and do not answer the questions.

Mark each year you received ADC checks (welfare)?

(40)
1. ___ 1980
2. ___ 1981
3. ___ 1982
4. ___ 1983
5. ___ 1984
6. ___ 1985

How many children do you have?
(Mark only one)

(41)
1. ___ 1
2. ___ 2
3. ___ 3
4. ___ 4
5. ___ 5
6. ___ 6
7. ___ 7 or more

How many of your children live with you?
(Mark only one)

(42)
1. ___ 1
2. ___ 2
3. ___ 3
4. ___ 4
5. ___ 5
6. ___ 6
7. ___ 7 or more

How old is the youngest child living with you?
(Mark only one)

(43)
1. ___ Less than 1 year
2. ___ 1 to 5 years
3. ___ 6 to 15 years
4. ___ 16 to 17 years
5. ___ 18 years

How old were you when your first child was born?
(Mark only one)

(44)
1. ___ 14 or younger
2. ___ 15 to 17
3. ___ 18 to 19
4. ___ 20 to 24
5. ___ 25 to 30
6. ___ Over 30

What is your marital status?
(Mark only one)

(45)
1. ___ Never married
2. ___ Divorced
3. ___ Married living with spouse
4. ___ Widowed
5. ___ Separated

How long has it been since you had a job?
(Mark only one)

(46)
1. ___ Never worked
2. ___ Less than 6 months ago
3. ___ 6 months to 1 year ago
4. ___ 1 to 2 years ago
5. ___ More than 2 years ago
6. ___ Working now

How much did you make on your last job?
(Or on your current job if you are working)
(Mark only one)

(47)
1. ___ Never worked
2. ___ Less than \$3 per hour
3. ___ \$3 to \$4 per hour
4. ___ \$4 to \$6 per hour
5. ___ \$6 to \$10 per hour

How far have you gone in school?
(Mark only one)

(48)
1. ___ No schooling
2. ___ 1st to 8th grade
3. ___ 9th to 11th grade
4. ___ Finished high school or GED
5. ___ More than high school

(PLEASE SEE BACK OF PAGE FOR MORE QUESTIONS)

What special job training have you had beyond high school? (Mark only the most recent training)

1. ___ None
2. ___ WIN
3. ___ Job Club
4. ___ CWEP (Community Work Experience)
5. ___ CETA
6. ___ JTPA
7. ___ Vocational/Technical school
8. ___ Other trade school
9. ___ Other job training

Have you ever used day care for your children? (Mark only the most recent type of day care used)

	1. ___ Never	4. ___ Day care center
(50)	2. ___ Family	5. ___ Day care in a home
	3. ___ Friends	6. ___ Other day care

If you have a job or if you could get a job, do you know anyone who could take care of your children? (Mark only one)

	1. ___ No	4. ___ Day care center
(51)	2. ___ Family	5. ___ Day care in a home
	3. ___ Friends	6. ___ Other day care

What problem makes it most difficult for you to work or find a job? (Mark only one)

(52)
1. ___ No day care available
2. ___ Day care too expensive
3. ___ Not enough education
4. ___ Not enough job training
5. ___ No way to get to work (no car, bus, or other transportation)
6. ___ Not enough work experience
7. ___ Might lose medical benefits
8. ___ Other ______________________________

Was your mother under 20 when she had her first child? (Mark only one)

(53)
1. ___ Yes
2. ___ No
3. ___ Not sure

If you want to write comments or explanations please put them here.

____

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