Approved 3-3-86
Date

MINUTES OF THE SENATE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Senator Edward F. Reilly, Jr. at
Chairperson

11:00 a.m./~~p.m.~~ on February 26, 19 86 in room 254-E of the Capitol.

All members were present ~~except~~

Committee staff present: Sharon Efird, Secretary

Conferees appearing before the committee:

Pat Goodson, Right to Life of Kansas, Inc.
Dr. Robert Harder, Secretary of Department of Social and Rehabilitation Services
Adele Hughey, Executive Director, Comprehensive Health Associates, Overland Park
Melissa L. Ness, National Board Member, National Abortion Rights Action League
Kathie Klepinger, Director of Nursing, Comprehensive Health Associates, Overland Park
Margo Smith, Director of Counseling, Comprehensive Health Associates, Overland Park
Emily Kofran, private attorney, Topeka
Belva Ott, Public Affairs Director, Planned Parenthood of Kansas
Carol Ramirez, Topeka-Shawnee County County Health Department
Darlene Stearns, State Co-ordinator, Religious Coalition for Abortion Rights in Kansas
Linda R. Johnson, President, League of Women Voters of Kansas
Theresa Shively, Executive Director, Kansas National Abortion Rights Action League
Anne Moriarty, Kansas National Organization for Women

Testimony before the Committee today is concerning SB 577 - consent to abortions performed on minors; defining crimes relating to abortion.

Pat Goodson requested to be heard as neither a proponent or opponent of the bill but wanted to make a general statement about the bill. She represents Right to Life of Kansas, Inc. and her testimony is Attachment #1. She pointed out that Kansas common law principles as a general rule require parental consent to authorize an operation on a minor. The need for parental consent could be circumvented if a physician declared abortion to be a medical emergency. She offered an amendment with the intent to leave present law and the definition of abortion intact, and to remove the emergency provision and said she would be supportive of the bill if such an amendment were made.

Dr. Robert Harder, Secretary of Social and Rehabilitation Services, appeared concerned that legislation would be passed that seems to tackle the issue; and, once it is passed we would sit back and think the problem of teenage pregnancy was solved. The problem that SB 577 deals with is broader than one piece of legislation and needs more attention than one bill. Material quoted from a demographic study concerning family status and a December 1985 SRS publication entitled "A Kansas Agenda for Investing in Women and Children" were distributed (Attachments #2 and #3).

Adele Hughey, Executive Director of Comprehensive Health Associates, a state licensed ambulatory surgical center, opposed SB 577 because of some of the basic assumptions being made and the consequences to teens in difficult life situations. Fact sheets with statistical information about abortions, discussing the safety of abortion, and explaining an abortion, were passed out along with instructions for post-abortion care.(Attachment #4) She outlined the counseling and advising procedures a patient undergoes at her facility. Passage of the bill would cause further delay in the decision-making process leading to more second trimester abortions or more teen parents. Her testimony is Attachment #5.

The next conferee, Melissa Ness, LMSW, a second year law student at Washburn and National Board Member of National Abortion Rights Action League, said her organization is dedicated to keeping abortion a safe, legal and accessible choice and sees SB 577 as a restriction on a minor's access to abortion. She sees the bill as focusing on the rights of parents, not problems created for adolescents. In her statement, Attachment #6, she urged the committee to spend more time developing legislation that would prevent the need for abortion.

Kathie Klepinger, a registered nurse and the Director of Nursing at Comprehensive Health Associates, sees delay and the abortion technique as two factors which lead to mortality and morbidity. One can choose the safest technique but cannot control for delay if parental consent for minors is required. She feels abortion in a state licensed surgical facility such as Comprehensive Health Associates is safe and extremely regulated.

Margo Smith, Director of Counseling at Comprehensive Health Associates, explained the five important topics covered in the 1 to 1½ hour counseling sessions their patients go through: 1) explanation of the procedure, 2) follow-up care, 3) explanation of the consent form and possible risks, 4) future birth control, and 5) the patient's decision to have the abortion. They are concerned that the patient is sure of her decision. Parental knowledge does not always have positive outcomes for teenagers. (Attachment #7)

Emily Kofran, a private attorney in Topeka and past Board President of Kansas National Abortion Rights Action League, feels that no lawyer can be assured of the constitutionality of SB 577. The U.S. Supreme Court has never ruled on a parental consent bill in the abortion context once that bill was actually implemented. She feels SB 577 is deficient in requiring the signature of both parents and that the judicial bypass procedure puts up insurmountable barriers to teenagers. It is her opinion that the bill is attempting to prevent a minor's access to abortion and is not a permissible goal of state legislature.

Belva Ott appeared as Public Affairs Director for Planned Parenthood of Kansas. They do not feel that every family is a perfect family. Their question is, will this bill restrict a teenager's access to abortion so that their only option is to go out of state, seek an illegal abortion, or delay receiving help? They feel the legislature should not pass a bill which infringes on individual minors' rights - a law which isn't in the best interest of every citizen of Kansas. A copy of her testimony is Attachment #8. She called the Committee's attention to the testimony of Gordon Atcheson, a lawyer in Wichita and member of the Board of Directors of Planned Parenthood of Kansas, which had been distributed. His testimony, Attachment #9, addresses certain fundamental legal questions posed, as to the constitutionality of the bill, and problems created by the bill.

Next to appear was Carol Ramirez, a licensed Master Social Worker with the Topeka-Shawnee County Health Department. She is involved with the counseling in their pregnancy testing program. They make an honest effort to encourage, minors specifically, to talk with their families. They do have concerns that not all families are functioning as well as they should and that the teenager may be in a family where lines of communication are not opened. The number of second trimester abortions may be increased for these young women.

Darlene Stearns, State Coordinator for Religious Coalition for Abortion Rights in Kansas, called the Committee's attention to an innovative program in a Chicago high school. It is a free clinic which treats children only after they have received written permission from their parents. Birth control devices are dispensed to 25% using the clinic. She feels this program prevents pregnancies and therefore abortions, and such programs should be considered as a solution to the problem. (Attachment #10)

Linda R. Johnson, President, League of Women Voters of Kansas, presented the announced position of the League (Attachment #11). She expressed a concern of the League that the criminal penalties attached to this bill would curtail a woman's right to a safe and legal abortion.

Theresa Shively as Executive Director of Kansas National Abortion Rights Action League, expressed the belief that all women should have access to safe and legal abortions and opposes the bill since it attempts to prohibit or obstruct young women from terminating their pregnancies. (Attachment #12) She also read a letter written to President Reagan by a minor who had an abortion (Attachment #13).

Anne Moriarty, Kansas National Organization for Women, agreed with a statement made by a proponent and re-phrased the statement to say: "Abortion is not the problem, abortion is one answer to the problem, the problem is teenage pregnancy." She referred the Committee to the February 1986 issue of State Legislatures and its story of what the Wisconsin Legislature has done in the Wisconsin Abortion Prevention and Family Responsibility Act of 1985. (Attachment #14)

The meeting adjourned at 12:09 p.m.

KANSAS SENATE FEDERAL AND STATE AFFAIRS

February 26, 1986

Mr. Chairman, members of the committee. My name is Pat Goodson. I represent Right To Life of Kansas. We appreciate the opportunity to provide input and perhaps make you aware of some of the ramifications of Senate Bill 577 that need to be considered. We commend the supporters of this bill for their good intentions, unfortunately the bill as presently drafted simply does not accomplish what they apparently believe it does, and we may be better off with the status quo. Further by redefining abortion senate bill 577 could preclude the possibility of outlawing at some future date early non-surgical abortions.

Attached to my testimony is an article describing the latest in abortion techniques. The abortion of the future will not be a surgical procedure. It will be a pill such as RU 486. One of the "advantages" of RU 486 is that it can be taken whether a woman knows she is pregnant or not. Thus under the definition of abortion in lines 44 through 49 an abortion induced by RU 486 or a similar drug could not be classified as an abortion because the woman would not be "known to be pregnant". This definition adds nothing to the bill. The present definition of pregnancy as beginning from the date of conception would be repealed in Section 7.

Right To Life of Kansas strongly supports and believes in the right of parents to counsel their minor children. We have opposed the many attempts over the past sixteen years to legalize "family planning" services to minors without parental consent. "Family planning" is often a euphimism for abortion. We have consistently opposed the tax funding of family planning to minors through county health agencies and private planned parenthood facilities.

Senate bill 577 begins with a flawed premise. The presumption is made that it is legal for any minor to receive an abortion in Kansas without her parent's knowlege or consent. This is not true. The Kansas abortion statute does not require the unmarried minor to obtain parental consent, but Kansas common law principles as a general rule require parental consent to authorize an operation on a minor. Moreover K.S.A. 38-123 authorizes an unmarried pregnant minor to request medical care related to her pregnancy and inferentially requires parental consent when a parent is available..

Attachment #1

In an opinion dated March 1983 the Attorney General reviewed the status of Kansas law regarding the ability of minors to consent to certain medical procedures. He opines that under the common law some minors may be capable of giving informed consent to receive medical treatment, and whether a particular individual is capable of giving informed consent to receive contraceptives or medical treatment is a question of fact to be determined on a case by case basis.

The Roe and Doe decisions of the supreme court placed the right to obtain an abortion within the constitutionally guaranteed right to privacy. Some parameters of constitutionally permissable regulation of a minor's right to abortion are enunciated in Bellotti v. Baird, -U.S.-, 99 S. Ct. 3035 (1979). The court concluded:

> "under state regulations such as that undertaken by Massachusetts, every minor must have the opportunity - if she so desires - to go directly to a court without first consulting or notifying her parents. If she satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent. If she fails to satisfy the court that she is competent to make this decision independently, she must be permitted to show that an abortion nevertheless would be in her best interest. If the court is persuaded that it is, the court must authorize the abortion. If, however, the court is not persuaded by the minor that she is mature or that the abortion will be in her best interest, it may decline to sanction the operation...If, all things considered, the court determines that an abortion is the minor's best interest, she is entitled to court authorization without any parental involvement. On the other hand the court may deny the abortion request of an immature minor in the absence of parental consultation if it concludes that her best interest would be served thereby, or the court may in such a case defer decision until there is parental consultation in which the court may participate.

Kansas has several statutes which address the issue of consent for medical procedures on behalf of minors. Paental consent is usually required prior to the performance of medical procedures. In Younts v. St.

Francis Hospital, 205 Kan. 292 (1970) Kansas recognized Bellotti's "mature minor" rule. In Younts, the Kansas Supreme Court held that a minor "mature enough to understand the nature and consequences and to knowingly consent to the beneficial surgical procedure," may give such consent without parental consent.

The abortionist who performs an abortion on a minorwithout having obtained parental permission or judicial consent does so at risk. This is the status of the law now. Parents who are able to discover that their daughter is seeking an abortion are able to obtain a court hearing. Wehave been involved in some of these cases. Recently, a distraught mother called one of our local offices seeking help in stopping her daughter from obtaining an abortion. This mother was able to obtain a hearing at which the judge determined that the abortion was not in the minor's best interest. She saved the life of her grandchild and spared her daughter the trauma of an abortion. If S577 in its present form were law, I am convinced the abortion would have taken place . This is so because of the emergency clause in Section 5 which states that if a medical emergency exists the parental and judicial consent provisions may be waived. Further, a medical emergency is to be determined by the abortionist and his judgement cannot be questioned. In the case I just mentioned the psychiatrist claimed that an emergency existed because the girl was having nightmares over her mother's efforts to stop the abortion.

We do not disagree with the stated objectives of SB 577, we just dispute the fact that it does what it's supporters claim it does. For instance oneof the conferees yesterday stated unequivocally that SB 577 "would require a teenage girl to obtain her parents written and informed consent before she could have an abortion."

That simply is not the case. The parental veto is a figment of the imagination. It is overridden at the whim of a judge - or more alarmingly - of an abortionist with a financial gain at stake. Only if the minor is under 14 may the court even consider notifying the parents, and if the minor's boyfriend has cash in hand and the abortionist is so inclined he may simply declare that the abortion is an emergency. He need not justify the circumstances of the emergency in any manner and he may not be questioned in such a judgement.

Under present reporting requirements there is no way to discover that such an abortion was performed, unless the abortionist elects to voluntarily report it.

Mr. Chairman we propose that SB 577 be amended as follows: Strike Lines 44 through 49 and renumber sections (b) through (f). Strike all of Section 5. Strike Lines 182 through 209 and insert the following Section 6. K.S.A. 21-3407 is hereby amended by adding a new section 1 (a) as follows. Section 6 is renumbered as Section 5.

Strike Lines 218through 234. Section 10 through 14 are renumbered as 8 through 12. In Line 264 and in the title strike K.S.A. 21-3407.

The intent of this amendment is to first leave the present law and definition of abortion intact, and second to remove the emergency provision.

Respectfully submitted

Patricia Ann Goodson,
Right To Life of Kansas, Inc.
Crosby Place Mall
717 So Kansas Avenue
Topeka, Kansas 66603

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

March 21, 1983

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ANTITRUST 296-5299

ATTORNEY GENERAL OPINION NO. 83- 39

Honorable Roy M. Ehrlich
Senator, Thirty-Fifth District
Room 138-N, State Capitol
Topeka, Kansas

Re: Infants--General Provisions--Consent to Receive Medical Services

Public Health--Healing Arts--Treatment of Minors

Synopsis: The existence of statutes which provide that persons who have attained a prescribed age can give informed consent to receive medical treatment under certain circumstances, or which expressly relieve a physician or other health care provider from civil liability for competently furnishing certain medical services to minors, does not preclude the possibility that a particular minor may be capable of giving informed consent to receive other medical services or contraceptives. However, absent a statute which prescribes that all persons of a prescribed age can give informed consent to receive contraceptives or medical treatment, or which expressly relieves a physician or other health care provider from liability for providing contraceptives or medical treatment to persons less than the statutorily-prescribed age of majority, it would be a question of fact for the trier of facts to determine whether informed consent could be given by a particular person and whether such consent indeed had been given. Cited herein: K.S.A. 38-101, 38-123b, 65-2891, 65-2892, 65-2892a.

* * *

treatment. See Younts v. St. Francis Hospital & School of Nursing, supra, at Syl. ¶s 6 and 7. Thus, these statutes merely provide a legal defense to a hospital, physician or other health care provider in the event it is sued for providing medical services to persons who have not attained the statutorily-prescribed age of majority. The existence of these statutes, however, in our judgment does not preclude the possibility that particular minors may be capable of giving informed consent to receive other medical treatment, thereby providing a legal defense to a claim of unauthorized treatment.

However, absent a statute which prescribes that all persons of a certain age can give informed consent to receive contraceptives or medical services, or which expressly relieves a physician or other health care provider from liability for providing contraceptiv or medical treatment to persons less than the statutorily-prescribed age of majority, it would be a question of fact for the trier of facts to determine whether informed consent could be given by a particular person and whether such consent indeed had been given.

Thus, whether a particular individual is capable of giving informed consent to receive contraceptives or medical treatment is a question of fact to be determined on a case-by-case basis. Factors identified by the courts as being relevant to the determination of this issue include the age and maturity of the individua the marital status of the individual, the degree to which the minor is dependent upon his or her parents or others for support, the familial situation of the minor, and the degree of potential health hazards associated with the particular contraceptive or medical treatment provided. See: H. L. v. Matheson, 450 U.S. 398, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981); Bellotti v. Baird, supra; Planned Parenthood of Missouri v. Danforth, supra; Eisenstadt v. Baird, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972); Younts v. St. Francis Hospital & School of Nursing, supra, and 61 C.J.S., Physicians, Surgeons, Etc., §178.

In light of the foregoing facts, I trust you understand it is not possible for us to state, as a matter of law, that any particula minor (i.e., any person who has not attained the age of 18 years), can or cannot give informed consent to receive contraceptives or

RU 486 – ABORTION IN A NEW PILL

In 1982 French inventor and scientist Professor Etienne-Emile Baulieu, an authority on reproductive chemistry, announced his discovery of RU 486 – a steroid compound designed to "regulate" the menstrual cycle. An RU 486 pill would not only regulate the menstrual cycle where there is no pregnancy, but would also work to terminate the pregnancy, were one to exist.

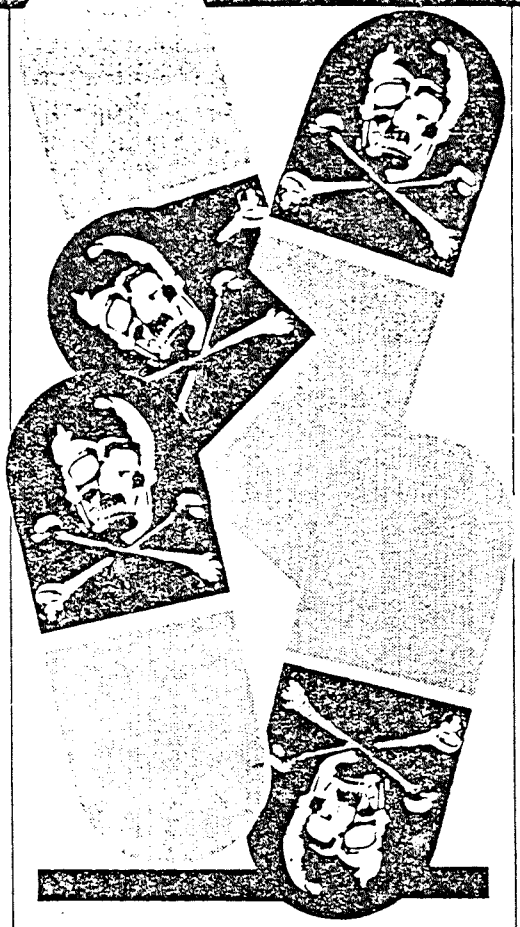
In other words, this new discovery, now being tested in the United States, would enable any female who even believes that she might be pregnant to terminate the life of an innocent child by simply taking the pill.

How does this steroid work?

The effect of RU 486 is to jam the protein receptor within the womb through which the cells of the uterus are able to absorb progesterone. Progesterone prepares the uterine cells to accept, lodge and sustain fertilization. If a fertilized egg has been implanted, Baulieu says, the pill produces the effect of an early abortion. Otherwise, the pill will produce a more or less normal menstruation.

Physicians in America have claimed, on 20/20, Nightline and elsewhere, that this pill could be the dawning of the most effective birth control ever because instead of causing a hormone imbalance in the female, this pill simply inactivates a hormone (progesterone) which is already present in the female system. Thus, if this new pill were to be approved, women would be able to take it once a month expressly for the purpose of abortion, if that were their concern.

Pharmacists for Life has explained to American Life League that Roussel-Uclaf (RU) is a French company which does business in the United States under the name of



Hoescht-Roussel. They are, as we are told, a research-oriented and successful pharmaceutical manufacturer known for such famous products as Lasix, Doxidan, Surfak, DiaBeta, Topicort, Loprox and Trental. This firm specializes in wholesale provision, and therefore sales representatives are rarely seen.

A most ironic twist to the story of this firm is that they released DiaBeta a year ago in Europe for the treatment of diabetes, and when the FDA approved that drug for use in the United States, Roussel-Uclaf sold the licensing rights for DiaBeta to none other than Upjohn, who is now marketing DiaBeta under the name Micronase.

RU 486 is now going through many testing trials in the Unit States, and will ultimately have to approved by the Food and Drug A ministration. This process could ta as little as five years, or perha longer. No matter the length time, the concern of the pro-l movement is essential and our effo to prohibit the ultimate approval such an abortion-causing chemi must start now.

Basic biology tells us that l begins at the moment of fertili tion. And, as the pro-life moveme is aware, the birth control pill as know it today and the intra-uteri device (IUD) both work to aggrava the lining of the uterus and th make implantation impossible f the tiny human life. While the p and the IUD have already abort perhaps billions of future Americar the pharmaceutical houses are n ready to openly promote this n pill as abortion – a forthright prom tion of abortion after 20 years desensitizing the American public never admitting or publicizing t fact that the birth control p presently on the market also work abort innocent human life.

It is our position that because t American public is so complet "birth control pill"-oriented, t drug companies will have little position to the new abortion p RU 486, unless the pro-life mo ment takes its stand now and firm denounces the birth control pill old, the IUD and RU 486 togeth as chemical and devices which ta innocent human life: Chemicals a devices that work not as true c traceptives but rather as abortic causing agents.

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between this new pill and the pills and IUDs which are on the market now. Abortion occurs when the fertilized ovum cannot implant itself on the womb's wall. This sort of abortion has been occurring within wombs-turned-to-tombs for so many years that the American public is now able to be very apathetic about the situation. Thus, and this is our deepest concern, this new pill is simply accepted without question.

RU 486 must be stopped in its tracks, and if pro-life people do not act swiftly and intelligently, the future of our efforts to protect these innocent children created in the image and likeness of God is surely going to be very dim, if not extinguished.

The leaders of the pro-life movement have known since 1968 that the birth control pill as we know it today and the IUD abort children. Though the primary action of the birth control pill may not be abortion, a secondary action is! And, because leadership has been silent in the past on this subject, the time has come to break the silence, clarify true contraception versus killing agents in pills and IUDs, and thus work with members nationwide to stop RU 486 before it ever has a chance to wreak its havoc in the wombs of women across our land and throughout the world.

Here Is a Lesson:

Professor Jerome Lejeune writes: "Life has a very, very long history but each individual has a very neat beginning; the moment of his or her conception (fertilization). As it has been amply demonstrated the whole biology of vertebrates teaches us that ancestors are united to their progeny by a continuous material link, for it is from fertilization of the female cell (the ovum) by the male cell (the spermatozoon) that a new member of the species will emerge.

"As soon as the 23 maternal chromosomes encounter the 23 paternal chromosomes, the full genetic information, necessary and sufficient to spell out all the inborn qualities of the new individual, is gathered.

"Exactly as the introduction of a minicassette inside a tape record will allow the 're-creation' of the symphony, the information included in the 46 chromosomes (the minicassettes of the symphony of life) will be deciphered by the machinery of the cytoplasm of the fertilized egg (the tape recorder), and the new human being begins to express himself as soon as he has been conceived (fertilized)."

"If a man professes a value and doesn't live it in his own life, he is called every sort of hypocrite under the sun. But maybe the thing is, that he did profess it and try to live up to it, even if he failed. We should always be at least one small dream ahead of reality."

–Sir A. William Liley

Professor Lejeune thus reaffirms what we already know–human life begins, as does all other biologic vertebrate life–at the moment of fertilization. And to build on his analogy, an abortion-causing chemical or device, like the now-popular birth control pill, the IUD or RU 486, works to kill the life, to stop the symphony by bombing the music hall in which the concert is taking place.

Ask Yourself This Question:

Can I stand on the sidelines and not do all within my power to protect innocent human life from the moment of fertilization without regard to age, health or condition of dependency?

If the answer is no, I must do something, then we want to give you more information as soon as we have it, so we can stop RU 486 before it comes to market. Write for the Death Pill Action Packet, A.L.L., P.O. Box 1350, Stafford, VA 22554.

You who read this are consumers, and you have a right to know exactly what research is being done, who is doing this research, who is funding this research, and what the exact side effects may be of this new steriod. We already know that one side effect is deadly–it kills innocent human life.

And, in addition, what will it do to the wombs of the mothers who decide, because of the morally handicapped society in which we live, that they will kill this new life with a clear conscience because society has accepted this quiet killing for years in silence?

If the pro-life movement does not break this silence–who will?

By Judie Brown, President of American Life League.

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March 21, 1983

ATTORNEY GENERAL OPINION NO. 83- 39

Honorable Roy M. Ehrlich
Senator, Thirty-Fifth District
Room 138-N, State Capitol
Topeka, Kansas

Re: Infants--General Provisions--Consent to Receive Medical Services

Public Health--Healing Arts--Treatment of Minors

Synopsis: The existence of statutes which provide that persons who have attained a prescribed age can give informed consent to receive medical treatment under certain circumstances, or which expressly relieve a physician or other health care provider from civil liability for competently furnishing certain medical services to minors, does not preclude the possibility that a particular minor may be capable of giving informed consent to receive other medical services or contraceptives. However, absent a statute which prescribes that all persons of a prescribed age can give informed consent to receive contraceptives or medical treatment, or which expressly relieves a physician or other health care provider from liability for providing contraceptives or medical treatment to persons less than the statutorily-prescribed age of majority, it would be a question of fact for the trier of facts to determine whether informed consent could be given by a particular person and whether such consent indeed had been given. Cited herein: K.S.A. 38-101, 38-123b, 65-2891, 65-2892, 65-2892a.

* * *

Dear Senator Ehrlich:

You and Senators James L. Francisco, William "Bill" Mulich, August Bogina, Jr., and Edward J. Roitz have signed and sent to this office a letter seeking an opinion on whether, "under Kansas law, a minor can provide informed consent (without parental consent being given) to receive medical contraceptive services."

You state that several statutes have been enacted granting minors the authority to consent to certain medical treatment, and cite as examples K.S.A. 38-123b, 65-2891, 65-2892 and 65-2892a. Then, you state: "Apparently, then, minors cannot consent to medical treatment in Kansas unless specific statutory authority to give consent has been provided."

Please be advised, first, that, in our judgment, the statement that no minor can give informed consent to receive any medical treatment unless a statute confers upon all minors the authority to grant such consent is incorrect. We note that, in regard to particular medical treatment, minors may be capable of giving consent, even where a statute attempts to preclude this possibility. See: Bellotti v. Baird, 443 U.S. 662, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) and Planned Parenthood of Missouri v. Danforth, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976). We also note the Kansas Supreme Court case of Younts v. St. Francis Hospital & School of Nursing, 205 Kan. 292 (1970), wherein our Supreme Court ruled that a minor female, although not married or otherwise emancipated, was capable of giving consent to receive medical treatment, had in fact given such consent and, thus, was denied recovery of civil damages for receiving unauthorized treatment. Thus, based upon the above cited cases, we believe that, under the common law, at least some persons, although having not attained the statutorily-prescribed age of majority [i.e., 18 years of age in Kansas (K.S.A. 38-101)], or not having become emancipated, nonetheless may be capable of giving informed consent to receive medical treatment.

Futhermore, our opinion is not affected by the statutes you reference. Generally, those statutes do nothing more than protect a hospital, physician or other health care provider from being held liable for civil damages, if the hospital, physician or other health care provider competently furnishes medical treatment to minors, when certain circumstances, such as an emergency, exist or when a particular treatment is provided. All of these statutes, however, merely recognize, and waive, the general rule that medical treatment cannot be provided to a minor without the consent of the minor's parent or legal guardian, without the person rendering the treatment being subject to civil damages for unauthorized

treatment. See Younts v. St. Francis Hospital & School of Nursing, supra, at Syl. ¶s 6 and 7. Thus, these statutes merely provide a legal defense to a hospital, physician or other health care provider in the event it is sued for providing medical services to persons who have not attained the statutorily-prescribed age of majority. The existence of these statutes, however, in our judgment does not preclude the possibility that particular minors may be capable of giving informed consent to receive other medical treatment, thereby providing a legal defense to a claim of unauthorized treatment.

However, absent a statute which prescribes that all persons of a certain age can give informed consent to receive contraceptives or medical services, or which expressly relieves a physician or other health care provider from liability for providing contraceptive or medical treatment to persons less than the statutorily-prescribed age of majority, it would be a question of fact for the trier of facts to determine whether informed consent could be given by a particular person and whether such consent indeed had been given.

Thus, whether a particular individual is capable of giving informed consent to receive contraceptives or medical treatment is a question of fact to be determined on a case-by-case basis. Factors identified by the courts as being relevant to the determination of this issue include the age and maturity of the individual, the marital status of the individual, the degree to which the minor is dependent upon his or her parents or others for support, the familial situation of the minor, and the degree of potential health hazards associated with the particular contraceptive or medical treatment provided. See: H. L. v. Matheson, 450 U.S. 398, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981); Bellotti v. Baird, supra; Planned Parenthood of Missouri v. Danforth, supra; Eisenstadt v. Baird, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972); Younts v. St. Francis Hospital & School of Nursing, supra, and 61 C.J.S., Physicians, Surgeons, Etc., §178.

In light of the foregoing facts, I trust you understand it is not possible for us to state, as a matter of law, that any particular minor (i.e., any person who has not attained the age of 18 years), can or cannot give informed consent to receive contraceptives or

medical treatment. Facts relating to the particular individual would have to be considered and a judgment made based upon those facts.

Very truly yours,

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Constitutional Law: Permissible Requirements of Parental Consent for Abortion

The landmark decisions of *Roe v. Wade*[1] and *Doe v. Bolton*[2] placed the right to obtain an abortion within the constitutionally guaranteed right to privacy.[3] But, this right was conditioned[4] on the possibility an important state interest could justify its regulation.[5] Some parameters of constitutionally permissible regulation of a minor's right to abortion are enunciated in *Bellotti v. Baird*, — U.S. —, 99 S. Ct. 3035 (1979). The Court holds a state may require parental consent as a condition to abortion for an unmarried pregnant minor so long as the state provides alternative judicial authorization for the abortion. The minor must be afforded the opportunity to show she is mature and therefore capable of rendering consent without parental consent or that it is in her best interest to have an abortion. In either case, the proceedings must assure the controversy will be expedited and the minor will maintain anonymity, even as to her parents.[6]

Historically, the scope of the state's authority over the activities of children is broader than its authority over adults. Only certain specific rights have been expressly granted to minors.[7]

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1. 410 U.S. 113 (1973). In *Roe*, the constitutionality of Texas laws prohibiting abortion except when necessary to save the life of the mother was challenged. The Court traced the history of abortion, examined the state's purposes and interests underlying criminal abortion laws and found a right of personal privacy implied under the Constitution "[b]road enough to encompass a woman's decision whether or not to terminate her pregenancy." *Id.* at 153.

2. 410 U.S. 179 (1973).

3. Doe v. Bolton, 410 U.S. 179, 189 (1973); Roe v. Wade, 410 U.S. 113, 153, 164 (1973). *See* Comment, *Constitutional Law: Elimination of Spousal and Parental Consent Requirements for Abortion*, 16 WASHBURN L.J. 462, 462-63 n.3 (1977) (quoting Georgius, *Roe v. Wade: What Rights the Biological Father?*, 1 HASTINGS CONST. L.Q. 251 & nn. 2-8 (1974)).

> Privacy is deemed to be a right which emanates from and is peripheral to those expressly preserved by the Bill of Rights and an element essential to their full exercise, accordingly, protections for express rights, including Fourteenth Amendment prohibitions against State action, extend to a guarantee of privacy in the exercise of those rights. The Court remains divided in its opinion of what constitutes the specific source of this fundamental right. It may be derived from the intent and purposes of the Constitution and its Bill of Rights as "implicit in the concept of ordered liberty," as included within the "penumbras" of the first eight Amendments, as preserved to individuals by the Ninth Amendment, or as protected against undue State restriction by the Fourteenth Amendment."

Id.

4. It is important to note the right to privacy recognized in the abortion decisions is not absolute. A "compelling State interest" may limit certain "fundamental rights"; the right to privacy must be balanced with the state's interests in the health of the woman and potential life of the fetus. 410 U.S. at 154, 155, 156, 159. Moreover, the pregnant woman's privacy right only permits her to make the initial decision an abortion is desired. The physician bears the primary responsibility for the ultimate decision and its effectuation, *id.* at 164, and must apply his or her medical judgment to decide if the pregnancy is to be ended, *id.* at 163.

5. In *Roe* and *Doe*, the Court found the applicable state interests to be the health of the mother and the potential life of the fetus. The state may promote its interest in the potential human life when the fetus become "viable." 410 U.S. at 159-62, 164. The interest in the mother's health reaches a "compelling" stage at the end of the first trimester. *Id.* at 163, 164. "[F]or the period of pregnancy prior to this 'compelling point,' the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment the patient's pregenancy should be teriminated." *Id.* at 163.

6. — U.S. at —, 99 S. Ct. at 3048-49.

7. The law does not regard children as equals of their elders. But "whatever may be their

In *Planned Parenthood v. Danforth*,[8] the Supreme Court struck a statute which required an unmarried minor to obtain parental consent for an abortion.[9] The Court indicated a significant state interest could limit the effectiveness of a minor's consent for termination of her pregnancy.[10] Nevertheless, the Court held, "[T]he State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of

precise impact, neither the Fourteenth Amendment nor the Bill of Rights is for adults alone." *In re* Gault, 387 U.S. 1, 13 (1967).

Cases involving a child's constitutional rights have arisen primarily within juvenile court and school contexts. Within the juvenile system, the current notion is a child is entitled "not to liberty, but to custody." *Id.* at 17. If the child's right is merely custodial, it still is often virtually coextensive with an adult's rights. Children have been granted procedural rights. *In re* Gault, 387 U.S. 1 (1967) (rights to notice, counsel, confrontation, cross examination and against self-incrimination protected). *But cf.* McKeiver v. Pennsylvania, 403 U.S. 528 (1971) (state need not provide juveniles jury trial); Kent v. United States, 383 U.S. 541 (1966) (juvenile delinquency hearings need not always conform with all criminal trial requirements). Additionally, children have been given some substantive rights. Swisher v. Brady, 438 U.S. 204 (1978) (prohibition of double jeopardy); Breed v. Jones, 421 U.S. 519 (1975) (prohibition of double jeopardy); *In re* Winship, 397 U.S. 358 (1970) (guilt standard of proof beyond a reasonable doubt).

In the school context, minors have been afforded similar constitutional rights. They must be provided procedural due process before they can be suspended from school. Goss v. Lopez, 419 U.S. 565 (1975). *Accord*, Carey v. Piphus, 435 U.S. 247 (1978). They also have substantive rights. Ingraham v. Wright, 430 U.S. 651 (1977) (corporal punishment of school children implicates constitutionally protected liberty interest); Tinker v. Des Moines School Dist., 393 U.S. 503 (1969) (children entitled to constitutional protection of freedom of speech); Brown v. Board of Educ., 347 U.S. 483 (1954) (school children entitled to equal protection against racial discrimination).

However, minor's rights are often tempered by parental or family rights. Parental discretion to direct the child's education and religious upbringing is protected from unwarranted state interference. Freedom of personal choice in matters of family life is one of the liberties protected by the due process clause of the fourteenth amendment. Protection of that freedom could be a "compelling interest." *See* Smith v. Organization of Foster Families, 431 U.S. 816 (1977); Roe v. Wade, 410 U.S. 113 (1973); Wisconsin v. Yoder, 406 U.S. 204 (1972); Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923). *But cf.* Quilloin v. Wallcott, 434 U.S. 246 (1978) (statute requiring only consent of illegitimate child's mother for adoption does not offend father's due process right to freedom of choice in matters of family life); Rowan v. Post Office Dep't, 397 U.S. 728 (1970) (Brennan, J., concurring) (parent's right does not always restrict independent interest of children); Ginsberg v. New York, 390 U.S. 629 (1968) (family itself not beyond regulation in public interest); Prince v. Massachusetts, 321 U.S. 158 (1944) (state as *parens patriae* may restrict parent's control).

8. 428 U.S. 52 (1976).

9. *Id.* at 72-75. In both *Roe* and *Doe*, the Court expressly declined to comment on the constitutionality of parental consent requirements. In cases prior to *Danforth*, courts had determined requiring parental consent was unconstitutional by applying the *Roe* and *Doe* rationale. *See* Annot., 42 A.L.R.3d 1406 (1972) for cases subsequent to and prior to *Danforth*.

10. Planned Parenthood v. Danforth, 428 U.S. at 73, 75. *Yoder, Ginsberg, Prince, Pierce* and *Meyer* involved conflicts between parent and state. In the abortion context, a court is faced with a possibly distinguishable situation in that there is only a potential conflict. At least one court has recognized this distinction. Planned Parenthood Ass'n v. Fitzpatrick, 401 F. Supp. 554, 567 (E.D. Pa. 1975).

After *Danforth*, it is relatively clear the right to privacy extends to minors. However, Justice Brennan, in Carey v. Population Serv., Int'l, 431 U.S. 678 (1977) (*citing Danforth*), admitted the validity of restrictions on a minor's privacy rights were measured by a test "less rigorous than the 'compelling state interest' test applied to restrictions on the privacy right of adults." *Id.* at 693 n.15.

In Poe v. Gerstein, 517 F.2d 787 (5th Cir. 1975), the Fifth Circuit delineated four areas wherein there could be sufficient state interest to warrant requiring parental consent. It found these interests insufficient to condition a minor's consent by an absolute parental veto. It listed the interests as preventing illicit sex among minors, protecting minors from their own improvidence, fostering parental control and supporting the family as a social unit. *Id.* at 792. *See* Note, *Constitutional Law—Abortion—Parental and Spousal Consent Requirements Violate Right to Privacy in Abortion Decision*, 24 KAN. L. REV. 446, 450-55 (1976). These areas are now definitively established. *See* notes 32-34 *infra*.

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14. 428 U.S. at 73-74.

15. Baird v. Bellotti, 39

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19. Baird v. Bellotti, 39
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Moreover, the Court in *Danforth* curtailed the traditional limit on a minor's consent to medical services,[12] the common-law requirement for parental consent.[13] The Court adopted the "mature minor rule," allowing a minor to effectively consent to an abortion if she was mature and competent enough to understand the consequences and import of her decision.[14]

In *Bellotti v. Baird*,[15] plaintiffs[16] brought a class action seeking to enjoin enforcement of parts of a Massachusetts statute[17] which required every unmarried woman under eighteen to obtain the consent of both her parents before receiving an abortion. The statute also provided if one or both parents refuse such consent, consent may be obtained by court order.[18] The Massachusetts district court found the statute unconstitutional.[19]

11. Planned Parenthood v. Danforth, 428 U.S. at 74.

12. *Id.* at 73-74. *See* McNamara, *The Minor's Right to Abortion and the Requirement of Parental Consent*, 60 VA. L. REV. 305 (1974) (outlining common-law requirement of parental consent to medical services and exceptions from general rule carved by statutes and courts). *See also* Comment, *Constitutional Law: Elimination of Spousal and Parental Consent Requirements for Abortion*, 16 WASHBURN L.J. 462, 465-66 (1977).

13. The parental consent requirement is dervied from the common law of torts as well as the nature of the parent-child relationship. Any nonconsensual touching is a technical battery. Unless the physician first obtains parental consent, any medical treatment will expose the doctor to civil liability. Younts v. St. Francis Hosp. & School of Nursing, 205 Kan. 292, 469 P.2d 330 (1970); McNamara, *supra* note 12, at 309. There are exceptions to this common-law doctrine: emergency, emancipation and the mature minor rule. *Id.* at 309-11. Whether a minor is mature depends upon his or her ability "to understand and comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances which attend." Younts v. St. Francis Hosp. & School of Nursing, 205 Kan. at 300, 469 P.2d at 337.

14. 428 U.S. at 73-74.

15. Baird v. Bellotti, 393 F. Supp. 847 (D. Mass. 1975), *vacated*, 428 U.S. 132 (1976).

16. The named plaintiffs included: Parents Aid Society, Inc.; William Baird, president of Parents Aid Society, Inc. and director and chief counselor at its Massachusetts center which provides abortion and counseling services; Mary Moe I, the representative minor, under 18, pregnant at the time of filing the suit and desiring an abortion without informing her parents; and Gerald Zupnick, M.D., claiming to represent all physicians in Massachusetts who, without patients' parental consent, see minor patients seeking abortions. The named defendants were the Attorney General of Massachusetts and district attorneys of all counties in the Commonwealth. Jane Hunerwadel, representing Massachusetts parents of unmarried minor females of childbearing age, intervened. 428 U.S. at 132, 137-38.

17. MASS. GEN. LAWS ANN. ch. 112, § 12S (West 1979). In pertinent part the statute provides,

> If the mother is less than eighteen years of age and has not married, the consent of both the mother and her parents is required. If one or both of the mother's parents refuse such consent, consent may be obtained by order of a judge of the superior court for good cause shown, after such hearing as he deems necessary. Such a hearing will not require the appointment of a guardian for the mother. If one of the parents has died or has deserted his or her family, consent by the remaining parent is sufficient. If both parents have died or have deserted their family, consent of the mother's guardian or other person having duties similar to a guardian, or any person who had assumed the care and custody of the mother is sufficient. The commissioner of public health shall prescribe a written form for such consent. Such form shall be signed by the proper person or persons and given to the physician performing the abortion who shall maintain it in his permanent files.

Id.

18. *Id.*

19. Baird v. Bellotti, 393 F. Supp. at 857. The district court found the Massachusetts statute's purpose was to encumber the rights of all minors coming within its terms. *Id.* at 855. The court concluded the encumbrance of parental consent was impermissible. It noted while parents may have rights vis-a-vis their child of a constitutional dimension, the individual rights of the minor outweigh those of the parents in the abortion decision. *Id.* at 857.

The case first rose to the Supreme Court to be argued and decided with *Danforth*.[20] The Court vacated and remanded to the district court, indicating the district court should have abstained because it found the unconstrued statute susceptible to a construction by the state judiciary which might have avoided federal constitutional adjudication or materially changed the nature of the problem.[21]

On remand, the district court certified nine questions to the Massachusetts Supreme Court.[22] The supreme court construed the statute to require parental consent and notification in nearly all cases[23] and found the statute's alternative to parental consent rejected the "mature minor rule."[24] Using this construction, the district court again held the statute unconstitutional in creating an impermissible third-party veto and enjoined its enforcement.[25]

On direct appeal, the Supreme Court faces the issue whether the Massachusetts abortion statute requiring notification and consent of both parents or, if parental consent is not obtained, judicial determination of the efficacy of the minor's decision by measuring it against its assessment of her "best interest,"[26] is constitutional. In an eight-to-one decision, the Court holds the statute unconstitutional.[27]

20. 428 U.S. 132 (1976). Argued with *Danforth*, March 23, 1976; decided on July 1, 1976.

21. 428 U.S. at 146, 147. Although the Court did not decide the constitutional issue, it gave some guidance, suggesting a statute that prefers parental consultation and consent, but permits a mature minor, without undue burden, to obtain an order permitting abortion and an immature minor to obtain such an order when it is in her best interests, would be constitutional. *Id.* at 145. The Court cautioned against creating an absolute third-party veto. *Id.* at 145, 147-48.

22. Baird v. Bellotti, 428 F. Supp. 854 (D. Mass. 1977). Pertinent questions certified by the District Court are as follows:

> 3. Does the Massachusetts law permit a minor (a) 'capable of giving informed consent,' or (b) 'incapable of giving informed consent,' 'to obtain [a court] order without parental consultation?
>
> 4. If the Court answers any of question 3 in the affirmative, may the superior court, for good cause shown, enter an order authorizing an abortion, (a), without prior notification to the parents, and (b), without subsequent notification?
>
> 5. Will the Supreme Judicial Court prescribe a set of procedures to implement c. 112 [§ 12S] which will expedite the application, hearing, and decision phases of the superior court proceeding provided thereunder? Appeal?
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> 9. Will the Court make any other comments about the statute which, in its opinion, might assist us in determining whether it infringes the United States Constitution?

Bellotti v. Baird, — U.S. at — n.9, 99 S. Ct. at 3041 n.9.

23. Baird v. Attorney Gen., 371 Mass. 741, 360 N.E.2d 288 (1977).

24. *Id.* at 752-55, 360 N.E.2d at 296-97.

25. Baird v. Bellotti, 450 F. Supp. 997 (D. Mass. 1978), *aff'd*, — U.S. —, 99 S. Ct. 3035 (1979). The statute was found unconstitutional because it required parental notification before a court could hear a minor's application for consent authorization. *Id.* at 1000-02. Moreover, the statute was held to violate due process and equal protection insofar as it allowed a judicial veto of the mature minor's consent. *Id.* at 1003, 1004. Finally, the court characterized the Massachusetts statute as excessively broad on its face by improperly suggesting the existence of parental rights. The court conluded this formal overbreadth would impermissibly chill the minor's sensitive right to make an abortion decision. *Id.* at 1004.

26. Certified to the Massachusetts Supreme Court was the question: "If the superior court finds that the minor is capable, and has, in fact, made and adhered to, an informed and reasonable decision to have an abortion, may the court refuse its consent on a finding that a parent's, or its own, contrary decision is a better one?" Baird v. Attorney General, 371 Mass. at 277 n.5, 360 N.E.2d at 293 n.5. The Massachusetts court answered in the affirmative, saying a judge may determine if the "best interests" of the minor will be served by an abortion. In the "best interest" test, the judge makes the final decision. *Id.* at 277, 360 N.E.2d at 293.

27. Bellotti v. Baird, — U.S. —, 99 S. Ct. 3035, 3052, 3053, 3055. The plurality is composed of Chief Justice Burger and Justices Stewart, Powell and Rehnquist. Rehnquist concurs to create

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28. *Id.* at —, S. Ct.
29. *Id.* at —, 99 S.
30. — U.S. at —, 99
31. *Id.* at —, 99 S.
32. *Id.* at —, S. Ct.
33. *Id.* at —, 99 S.
34. *Id.* at —, S. Ct.
35. *Id.* at —, 99 S.

Gross v. Lopez, 419 U.S.
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36. *Id.* at —, 99 S.
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37. *Id.* at —, 99 S.
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A majority says both the parental consent requirement and the "best interests" test create an impermissible third-party veto.[28] Eight Justices agree a state can not require an abortion to be in the "best interest" of a minor if the minor is mature, *i.e.*, capable of making and having made an informed and reasonable decision to have an abortion.[29] Such a requirement would allow a state the final abortion decision. This requirement was resolutely rejected in *Danforth* and is now followed in *Bellotti*.[30]

Similarly, the eight Justices make it clear a state may not absolutely require a mature minor to obtain parental consent to her abortion decision.[31] The plurality[32] continues, emphasizing there could be a special state interest in encouraging an unmarried pregnant minor to seek advice from her parents.[33] While a child is not beyond the protection of the Constitution, the plurality affirms that rights of children may not equal those of adults.[34] The plurality advances three reasons to justify this conclusion: the vulnerability of children;[35] a child's inability to make critical decisions in an informed, mature manner;[36] and the importance of the parental role in child-rearing.[37]

Notwithstanding the child's special position in our society, the plurality says the Massachusetts statute provides for parental notice and consent in a manner that unduly burdens the pregnant minor's right to seek an abortion.[38] Moreover, the mere requirement of parental notice constitutes such a burden.[39] "The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement in

a rule for future guidance. *Id.* at —, 99 S. Ct. at 3038, 3053. Justices Brennan, Marshall, Blackmun and Stevens also concur. *Id.* at —, 99 S. Ct. at 3053. Justice White dissents for the same reasons he dissented in *Danforth*. *Id.* at —, 99 S. Ct. at 3055.

28. *Id.* at —, S. Ct. at 3046, 3050-52, 3053-55.

29. *Id.* at —, 99 S. Ct. at 3048-49 (following *Danforth*). *See* note 13 *supra*.

30. — U.S. at —, 99 S. Ct. at 3051-52.

31. *Id.* at —, 99 S. Ct. at 3047-48, 3054.

32. *Id.* at —, S. Ct. at 3038, 3053. *See* note 27 *supra*.

33. *Id.* at —, 99 S. Ct. at 3050 (plurality).

34. *Id.* at —, S. Ct. at 3043-46, 3051 (plurality).

35. *Id.* at —, 99 S. Ct. at 3043-44 (plurality) (citing Ingraham v. Wright, 430 U.S. 651 (1977); Gross v. Lopez, 419 U.S. 565 (1975); McKeiver v. Pennsylvania, 403 U.S. 528 (1971); *In re* Winship, 397 U.S. 358 (1970); *In re* Gault, 387 U.S. 1 (1967); Kent v. United States, 383 U.S. 158 (1944)).

36. *Id.* at —, 99 S. Ct. at 3045-46 (plurality) (citing Ginsberg v. New York, 390 U.S. 629 (1968); Prince v. Massachusetts, 321 U.S. 158 (1944)).

37. *Id.* at —, 99 S. Ct. at 3046-47 (plurality) (citing Wisconsin v. Yoder, 406 U.S. 205 (1972); Ginsberg v. New York, 390 U.S. 629 (1968); Prince v. Massachusetts, 321 U.S. 158 (1944); Pierce v. Society of Sisters, 268 U.S. 510 (1925)).

38. *Id.* at —, 99 S. Ct. at 3049-50 (plurality). The plurality contends an abortion decision is unique. The minor's options are limited. It notes she may not postpone her decision. Unwelcome motherhood may be "exceptionally burdensome" for a minor, considering her probable lack of education, employment skills, financial resources and emotional maturity. Under these circumstances, "the unique nature and consequences of the abortion decision make it inappropriate 'to give a third party an absolute, and possibly arbitrary veto . . . .'" *Id.* at —, 99 S. Ct. at 3047-48 (plurality).

39. *Id.* at —, 99 S. Ct. 3049-50 (plurality). The plurality concludes requiring parental consultation would unduly burden the minor's right. It finds it is unrealistic to assume minors could then freely decide as they are "particularly vulnerable to their parents' efforts to obstruct both an abortion and their access to court." *Id.* at —, 99 S. Ct. 3050 (plurality). The Seventh Circuit in Wynn v. Carey, 582 F.2d 1375 (7th Cir. 1978), had recognized this problem and offered additional examples. Parents may physicially abuse the minor or force her into a marriage she does not want or to continue her pregnancy simply as punishment. *Id.* at 1388 n.24.

this manner."[40]

The plurality contends some fostering of parental involvement may be required and might be particularly desirable.[41] But if a state would require parental consent as a condition to a minor's obtaining an abortion, a minor must be allowed a proceeding to show either:

> (1) That she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or
> (2) That even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.[42]

The full extent of parental involvement under the plurality's view would be allowed only when a court concludes it is in the "best interest" of an immature minor to have parental consultation.[43]

Four concurring Justices[44] criticize the plurality for addressing "the constitutionality of an abortion statute that Massachusetts has not enacted."[45] They suggest the plurality's requirement of judicial proceedings is advisory.[46] Moreover, they contend this decision does not determine the constitutionality of requiring notice to parents without affording them an absolute veto.[47]

Mr. Justice White dissents, believing it "inconceivable" the Constitution forbids notice to parents.[48] He continues to disagree with the Court's holding in *Danforth*, contending parental consent may be validly required.[49] He reasons even if a parental consent requirement of the kind involved in *Danforth* must be deemed invalid, the Massachusetts statute does not create an absolute parental veto because it allows a judge to permit an abortion, if it is in the best interest of the minor,[50] even when the parents object.

At least one court has followed the plurality's "advice."[51] The United States District Court in Southern Florida held the Florida Legislature failed to draft a statute imposing constitutionally permissible prerequisites to perform an abortion on a minor.[52] The Florida statute had avoided some of the Massachusetts statute's defects. For example, the Florida law would have allowed the minor to go directly to court without first notifying her parents and al-

40. Bellotti v. Baird, — U.S. at —, 99 S. Ct. at 3047 (plurality).
41. *Id.* at —, 99 S. Ct. at 3046, 3050-51 (plurality).
42. *Id.* at —, 99 S. Ct. at 3048-50 (plurality).
43. *Id.* at —, 99 S. Ct. at 3051 (plurality).
44. Justices Brennan, Marshall, Blackmun and Stevens. *Id.* at —, 99 S. Ct. at 3053 (Stevens, J., concurring).
45. *Id.* at —, 99 S. Ct. at 3054-55 (Stevens, J., concurring).
46. *Id.* (Stevens, J., concurring).
47. *Id.* at —, 99 S. Ct. at 3053 n.1 (Stevens, J., concurring). The plurality responds it is giving judges the guidance needed to avoid future protracted litigation. Additionally, it argues the issues exist as a unanimous court found them in its first *Bellotti* decision. *Id.* at — n.32, 99 S. Ct. at 3052-53 n.32 (plurality).
48. *Id.* at —, 99 S. Ct. at 3055 (White, J., dissenting).
49. *Id.* (White, J., dissenting).
50. *Id.* (White, J., dissenting).
51. Jones v. Smith, 474 F. Supp. 1160 (S.D. Fla. 1979).
52. *Id.* at 1166.

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lowed her to prove she was mature.[53] But the statute was deficient because, as the district court interpreted it, it would allow a judge to deny an abortion to a mature minor.[54] Furthermore, the statute did not provide the procedure envisioned by the plurality in *Bellotti*; the judicial proceedings would not assure expedition and anonymity in resolution of the issue.[55] Judicial discretion did not provide "sufficient expedition."[56]

The status of Kansas abortion law is unclear.[57] The Supreme Court's decision in *Bellotti* does not make that status any more certain. The Kansas abortion statute[58] does not require the unmarried minor to obtain parental consent. But Kansas common-law principles, as a general rule, require parental consent to authorize an operation on a minor.[59] Moreover, the statute concerning medical consent for an unmarried pregnant minor inferentially requires parental consent, when a parent is available.[60] The statute and common law are limited by the mature minor rule, accepted in Kansas prior to *Bellotti*.[61] However, the immature minor must still obtain parental consent and Kansas statutes do not provide for the alternative judicial proceedings envisioned in *Bellotti*. If the Kansas statute effectively requires parental consent, Kansas abortion law has another constitutional hurdle to clear.

The plurality in *Bellotti* provides only some of the parameters of constitutionally permissible regulation of a minor's right to an abortion. Seemingly, the mature minor's rights have been outlined. The decision leaves unresolved

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53. 1979 Fla. Sess. Law Serv., ch. 79-302, § 1 at 1824 (codified at FLA. STAT. ANN. § 458.505(4)(a) (West 1979)) (ruled unconstitutional in Jones v. Smith, 474 F. Supp. 1160 (S.D. Fla. 1979).

> If the pregnant woman is under 18 years of age and unmarried, in addition to her written request, the physician shall obtain the written informed consent of a parent, custodian, or legal guardian of such unmarried minor, or the physician may rely on an order of the Circuit Court, on the petition of the pregnant unmarried minor or another person on her behalf, authorizing, for good cause shown, such termination of pregnancy without the written consent of her parent, custodian, or legal guardian. The cause may be based on a showing that the minor is sufficiently mature to give an informed consent to the procedure, or based on the fact that a parent unreasonably withheld consent by her parent, custodian, or legal guardian, or based on the minor's fear of physical or emotional abuse if her parent, custodian, or legal guardian were requested to consent, or based upon other good cause shown. At its discretion the court may enter its order ex parte. The court shall determine the best interest of the minor and enter its order in accordance with such determination.

Id.

54. Jones v. Smith, 474 F. Supp. at 1166.

55. *Id.* at 1167.

56. *Id.* *See also* Bellotti v. Baird, — U.S. —, —, 99 S. Ct. 3035, 3054 (1979) (Stevens, J., concurring). The Court notes in the typical situation, judicial proceedings "would impose a burden at least as great as, and probably greater than, that imposed on the minor child by the need to obtain consent of a parent." *Id.* (Stevens, J., concurring). *Accord*, Wynn v. Carey, 582 F.2d 1375, 1389 (7th Cir. 1978).

57. *See* Note, *Constitutional Law—Abortion—Parental and Spousal Consent Requirements Violate Right to Privacy in Abortion Decision*, 24 KAN. L. REV. 446, 462 (1976) (discussing status of Kansas abortion law). The author said the Kansas abortion statute was "clearly defective" because Doe v. Bolton, 410 U.S. 179, 182 (1973), would invalidate the statute. *Id.* at 462. Part of the statute had previously been held unconstitutional. Poe v. Menghini, 339 F. Supp. 986 (D. Kan. 1972).

58. KAN. STAT. ANN. § 21-3407 (1974).

59. Younts v. St. Francis Hosp. & School of Nursing, 205 Kan. 292, 469 P.2d 330 (1970). *See also* notes 12-14 *supra*.

60. KAN. STAT. ANN. § 38-123 (1973).

61. Younts v. St. Francis Hosp. & School of Nursing, 205 Kan. at 300-01, 469 P.2d at 337-38.

the position of the immature minor with respect to a common-law requirement of parental consent. Must an alternative judicial authorization be provided?[62] However, the decision does make it clear a state may regulate the minor's right to abortion, although it may not create a third-party veto of a mature minor's abortion decision. And it can only legislate a presumption for parental consultation if it provides, as an alternative, avenues for anonymous and expedited judicial authorization.

Arthur S. Chalmers

62. Judicial discretion may not provide the guarantees of anonymity and expediency envisioned in *Bellotti*. *See* note 49 *supra*. However, *Bellotti* deals with a state statute, not common law. An immature minor must obtain parental consent to any medical operation under the common-law rule. Whether *Bellotti* will require affirmative judicial action to ensure expedition and anonymity in any method to judicially authorize an immature minor's consent to an abortion is an unanswered question. But, without a statute, how does the immature minor get to court?

SOCIAL AND REHABILITATION SERVICES
(Material quoted from a demographic study)

FAMILY STATUS: Major changes have taken place in the ways we live together. In 1955, 60% of the households in the U.S. consisted of a working father, a housewife mother and two or more school age children. In 1980, that family unit was only 11% of our homes, and in 1985 it is 7%, an astonishing change.

More than 50% of women are in the work force, and that percentage will undoubtedly increase. Of our 80 million households, almost 20 million consist of people living alone. The Census tells us that 59% of the children born in 1983 will live with only one parent before reaching age 18--this now becomes the NORMAL childhood experience. Of every 100 children born today:

- 12 will be born out of wedlock
- 40 will be born to parents who divorce before the child is 18
- 5 will be born to parents who separate
- 2 will be born to parents of whom one will die before the child reaches 18
- 41 will reach age "18" normally

The U.S. is confronted today with an epidemic increase in the number of children born outside of marriage--and 50% of such children are born to teenage mothers. Although the percentage of Black teenage girls who have children outside of marriage is higher than that of white girls, comparisons with other nations indicate that a white teenage female is twice as likely to give birth outside of marriage as in any other nation studied. The situation is most striking with very young mothers, age 13 and 14. Indeed, every day in America, 40 teenage girls give birth to their THIRD child. To be the third child of a child is to be very much "at risk" in terms of one's future. It appears that sexual activity among the young is no more frequent here than elsewhere; the major difference is the inability of American youth to get access to information about contraception. Information about abortion is similarly restricted, although the variations across states are wide--Mississipppi reports 4 abortions per 1,000 teenage live births, while New York reports 1,200 abortions compared to 1,000 teenage live births.

There is a particular aspect of this situation that is vital--teenage mothers tend to give birth to children who are premature,due mostly to lack of physical examinations and to their very poor diet while pregnant. Prematurity leads to low birth weight, which increases these infants' chances of major health problems due to the lack of development of the child's immune system. Low birth weight is a good predictor of major learning difficulties when the child gets to school. This means that about 700,000 babies of the annual cohort of around 3.3 million births are almost assured of being either educationally retarded or "difficult to teach". This groups is entering the educational continuum in rapidly increasing numbers.

Several other family factors are important to cite--first, with over half of the females in the work force (and almost 70% if you only consider "working age" women), the number of "latch-key children"--those who are home alone after school when adults are not present--has shown a major increase and will continue

to do so, as women increasingly opt for work AND children. (Of those mothers of one-year-olds, half have already returned to work.) The typical pattern for women today is (1) get settled in a job, (2) get married, and (3) have children, as opposed to the previous pattern of entering the work force only after the children were mature enough to fend for themselves. There are at least four million "latch-key" children in the U.S. of school age. Many of them think of home as a dangerous, frightening place, particularly if there are no other children in the home. They "check in" with parents by phone. They spend many hours watching TV and talking to their friends on the phone, and have to make decisions about knocks on the door and phone calls from strangers. The evidence is not yet in, and some children may benefit from having family responsibilities while home alone, but many others become problems at school.

Taken from All One System by Harold L. Hodgkinson
February 24, 1986

SOCIAL AND REHABILITATION SERVICES
(Information related to poverty and the future of schools)

To summarize the education consequences of demographic changes:

1. More children entering school from poverty households.

2. More children entering school from single parent households.

3. More children from minority backgrounds.

4. A smaller percentage of children who have had Head Start and similar programs, even though more are eligible.

5. A larger number of children who were premature babies, leading to more learning difficulties in school.

6. More children whose parents were not married, now 12 of every 100 births.

7. More "latch-key" children and children from "blended" families as a result of remarriage of one original parent.

8. More children from teenage mothers.

9. Fewer white, middle-class, suburban children, with day care (once the province of the poor) becoming a middle class norm as well, as more women enter the work force.

10. A continuing decline in the level of retention to high school graduation in virtually all states, except for minorities.

11. A continued drop in the number of minority high school graduates who apply for college.

12. A continued drop in the number of high school graduates, concentrated most heavily in the Northeast.

13. A continuing increase in the number of Black middle class students in the entire system.

14. Increased numbers of Asian-American students, but with more from Indonesia, and with increasing language difficulties.

15. Continuing high drop-outs among Hispanics, currently about 40% of whom complete high school.

16. A decline in the number of college graduates who pursue graduate studies in arts and sciences.

17. A major increase in part-time college students, and a decline of about 1 million in full time students. (Of our 12 million students, only about 2 million are full time, in residence, and 18-22 years of age.)

18. A major increase in college students who need BOTH financial and academic assistance. A great liaison between the offices of student financial aid and counseling will be essential.

19. A continuing increase in the number of college graduates who will get a job which requires no college degree. (Currently 20% of all college graduates.)

20. Continued increases in graduate enrollments in business, increased undergraduate enrollments in arts and sciences COURSES but not majors.

21. Increasing numbers of talented minority youth choosing the military as their educational route, both due to cost and direct access to"high technology."

22. Major increases in adult and continuing education outside of college and university settings--by business, by government, by other non-profits such as United Way, and by for-profit "franchise" groups such as Bell and Howell Schools and The Learning Annex.

23. Increased percentage of workers with a college degree. (From one to seven to one in four today.)

Taken from All One System by Harold L. Hodgkinson
February 24, 1986

Topeka Capital-Journal, Wednesday, February 19, 1986 29

Teen pregnancies cost U.S. $16.6 billion in '85

WASHINGTON (AP) — Teen-age childbearing cost the nation $16.6 billion last year, and the 385,000 children who were the firstborn of adolescents in 1985 will receive $6 billion in welfare benefits over the next 20 years, said a study released Tuesday.

The first baby born to a teenager last year will receive $15,620 in welfare payments and other government support by the time the child reaches age 20, according to the study released by the privately financed Center for Population Options.

By the time these babies reach age 20, the government will have spent $6.04 billion to support them through Aid to Families with Dependent Children, Medicaid and food stamps, said the report, titled "Estimates of Public Costs for Teen-age Childbearing."

The center, founded in 1980, is dedicated to preventing unwanted teen-age pregnancies. It favors increased access to family planning and sexual education services for teenagers. The center also operates the International Clearinghouse on Adolescent Fertility, as well as a resource center on sex education.

The report said a third of the welfare total — $2.4 billion — could have been saved had teen-age mothers waited until they had reached age 20 to have their first baby.

The study estimated the government spent $16.5 billion last year in welfare costs to support the families started by teen-age mothers. This estimate includes payments for AFDC, Medicaid and food stamps as well as the costs of administering these programs.

"This figure represents minimal public costs in that it does not include other services such as housing, special education, child protection services, foster care, day care and other social services," the report's summary said.

A study by the Urban Institute estimated that in 1975, teen-age childbearing cost the nation $8.5 billion in welfare payments and administrative costs.

Echoing a study recently released by the House Select Committee on Children, Youth and Families, the center's report recommended that more money be spent on programs to prevent teen-age pregnancy.

See p. 27

A Kansas Agenda For Investing In Women And Children

December 1985

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

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.

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.

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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)

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)

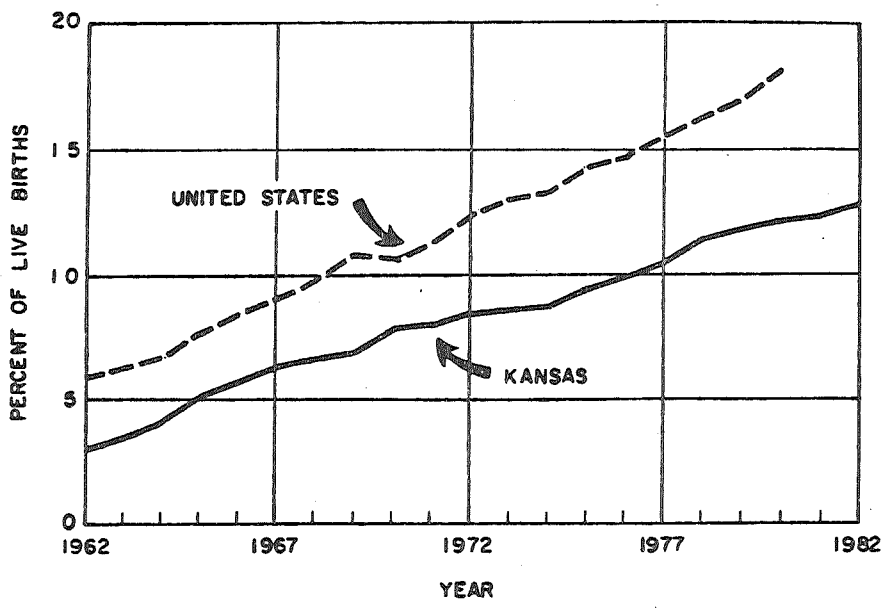
1955		1979	
Non-White	White	Non-White	White
78	6	87	15

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.

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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

14 or younger	3.2%	
15 to 17	23.0%	52.3%
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%

- **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.

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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.

- 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.)

- 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.

- 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.

- 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.

- Non-exempt clients are referred to the local Department of Human Resources WIN office.

- 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.

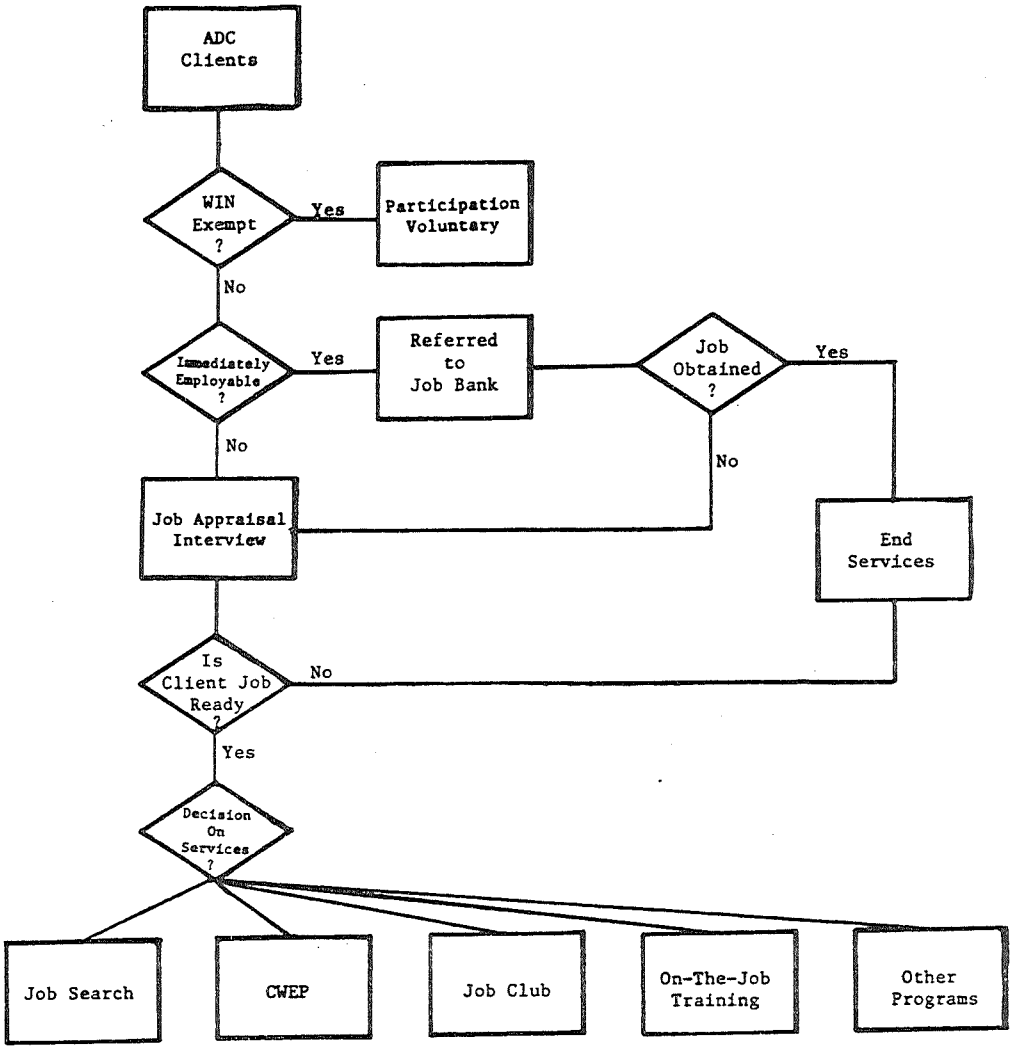
During the second week, Job Club participants call local employers using telephone techniques which describe their work skills and assets. Job interviews are obtained from these calls and completed by the participants. Since 80 percent of job openings are never advertised, this allows the Job Club participant 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.

- o On-The-Job Training - 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.

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

Flowchart of Job Programs Process For WIN Clients In Counties With Full WIN Services



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.

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.

- Recreational - This includes group outings to community events.
- Cottage Life - The residents live in group cottages and learn in this supervised setting to live together cooperatively.
- 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 teenagers 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:

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

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

- 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:

- 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.

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

- 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.

- o Select one urban area as a pilot test site.
- o 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.
- o 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.

- 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:

- Select a test site.

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

- 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 to pay for purchased services.

- 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.

- o Select one area as a pilot test site.
- o 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.
- o 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:

- o Select a test site.
- o Develop more detailed descriptions of the services to be provided.
- 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 travel costs.

- o 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:

- Select one SRS area office as a test site.

- 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.

- 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.

- 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:

- Select a test site.

- 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.

- Select a pilot test site.

- 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.

- 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:

- o Meet with the Department of Health and Environment and local health departments to seek support and agree on shared responsibilities.
- o Select a test site.
- o Develop more detailed descriptions of the services to be provided.
- 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 travel costs.
- o 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:

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

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

The steps involved in developing such a program include:

- 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.
- 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.
- Develop a plan for evaluating the success of the clinic.
- Arrange the administrative mechanisms to reimburse the clinics, when appropriate, through Medicaid.
- 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.

- Select one urban area as a pilot test site.
- 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.
- 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.

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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)

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

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

_____

_____

_____

_____

_____

_____

_____

_____

Adele Hagen

FACT SHEET

Women Who Have Abortions

The most current available data is for 1981. In that year, most women who had abortions were young, unmarried, white, and less than eight weeks pregnant.

Number Having Abortions

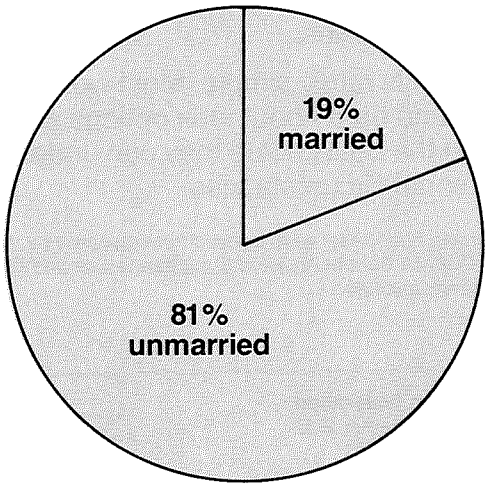
In 1981, 1.6 million women had abortions. Abortions end approximately one out of four pregnancies in the U.S.

Marital Status

Most women who have abortions are not married at the time of the abortion.

Married women give birth ten times more often than they have abortions, and they are much more likely than unmarried women to obtain sterilization (thus reducing their chance of becoming pregnant accidentally). Unmarried women have abortions twice as often as they give birth.

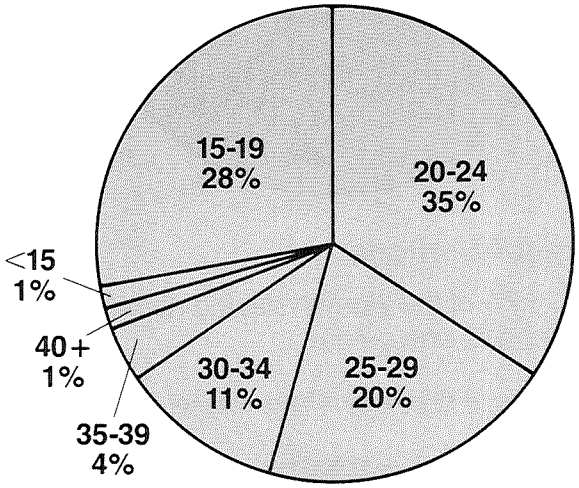
Percentage of all abortions by marital status.



Age

Nearly two-thirds of the women having abortions were 24 or younger.

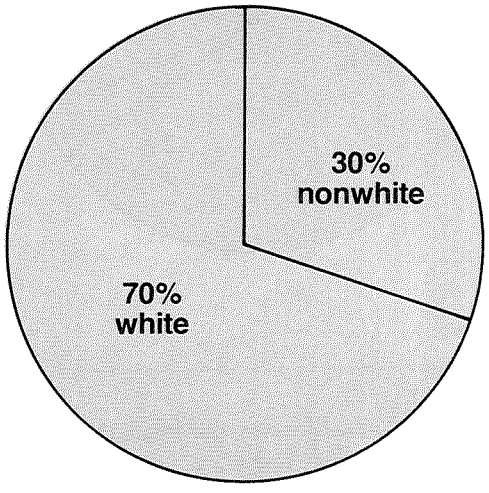
Percentage of all abortions by age.



Race

In the U.S., 70% of the women who obtain abortions are white.

Percentage of all abortions by race.

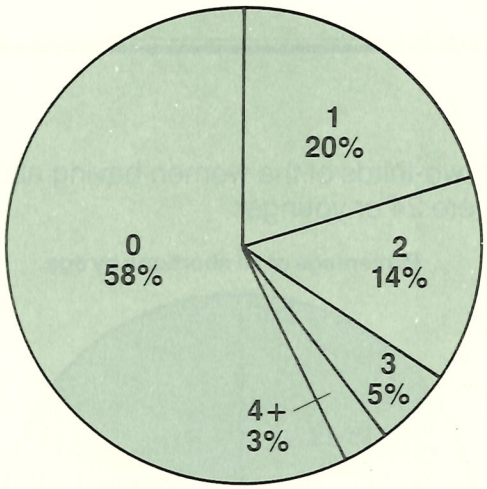


Looking at all women of reproductive age, 2.4% (24/1,000) of white women and 5.6% (56/1,000) of nonwhite women had abortions in 1981.

Previous Live Births

More than half of the women having abortions had not yet borne a child. One third had one or two children.

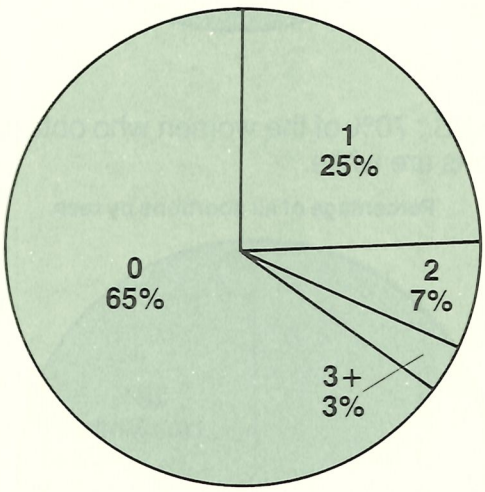
Percentage of all abortions by number of previous live births.



Previous Abortions

In 1981, 65% of the women having abortions had never had one before.

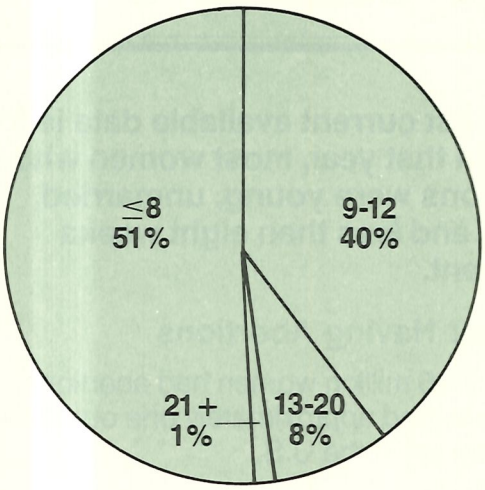
Percentage of all abortions by number of previous abortions.



Stage of Pregnancy

Most women obtain abortions in the first trimester of pregnancy — 13 weeks or less since the last menstrual period.

Percentage of all abortions by weeks since last menstrual period.



Reasons for Obtaining Abortions

Notwithstanding statistical trends of age, race, and marital status, the reasons women give for having abortions are as individual as the women themselves. Many did not intend to get pregnant. They speak of not being ready to be parents, being too young or too old, having too little money, feeling that another baby would make it harder to raise the children that have already been born, needing to finish school, not having supportive companions. Some women wanted to get pregnant but developed serious medical problems or learned that the fetus had severe abnormalities.

The decision is rarely simple. Most women think long and hard about their options and then make the best choice they can under their own, personal circumstances.

Statistics for this Fact Sheet were derived from research by the U.S. Centers for Disease Control Abortion Surveillance Unit and The Alan Guttmacher Institute.

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November 1985

FACT SHEET

Safety of Abortion

Abortions are now one of the safest medical procedures available. Having an abortion is seven times safer than bearing a child.

I heard abortions were dangerous.

They used to be very dangerous. Before 1973, when abortions were made legal, women died or had serious medical problems after going to untrained practitioners in often filthy surroundings or attempting to induce abortions themselves. Women streamed into emergency rooms with serious problems — a perforated uterus, retained placenta, severe bleeding, cervical wound, rampant infection, shock, gangrene. However, since legalization, women have benefitted from significant advances in medical technology and greater accessibility of services, making abortion (especially early abortion) an exceptionally safe procedure.

Do women still die from abortions?

Rarely. In 1981, only 1 of 200,000 women who had legal abortions died.

How likely are complications following an abortion?

That depends on a number of factors: the abortion method, the woman's age and health, the number of children she has had, the skill of the physician, and the kind of anesthesia used. The most important factor in determining complications is how far along the pregnancy is. Most women who obtain abortions are in their first trimester (less than 13 weeks) of pregnancy. Of these women, less than ½ of 1% experience major complications. Delaying an abortion beyond the first trimester, however, increases the probability of complications. Thereafter, the risks go up each week of pregnancy.

What are the possible complications from first-trimester abortions?

In the first trimester, infections — most of which are easily identified and treated — are the most common (occurring in less than 1% of cases). Occasionally, the procedure fails to end the pregnancy or is incomplete and must be repeated. Less frequent complications are excessive bleeding (.5% or 5/1,000 cases) and perforation (tearing) of the uterus (.005% or 5/100,000 cases). Minor perforations usually heal themselves, but a serious case might require surgical repair or, rarely, hysterectomy. Again, serious complications arising from first-trimester abortions are quite unusual.

What are the complications from second-trimester abortions?

As mentioned, the risk of complications increases weekly for second-trimester abortion (13-24 weeks), primarily infection, uterine perforation, cervical injury, bleeding that requires transfusion, and incomplete abortion. General anesthesia is occasionally used and carries its own risks.

What are the signs of a post-abortion complication?

If a woman has any of the following symptoms after having an abortion, she should immediately contact the facility that provided the abortion: chills or fever with an oral temperature of 100.4° or more, severe pain, bleeding that is heavier than the heaviest day of her normal menstrual period or that saturates more than one sanitary pad per hour, or foul-smelling vaginal discharge or drainage.

Can a woman do anything to prevent complications?

To some extent, complications are a matter of

chance, but there are some things women can do to lower their risk. The most important thing is not to delay; the earlier the abortion, the safer it is. Asking questions is also important. Just as with any medical procedure, the more relaxed a person is and the more she understands what to expect, the better and safer her experience will be.

Other things she can do to make her abortion safer include finding a good clinic or a qualified, licensed physician (for referrals, call NAF's toll-free hotline, 800-772-9100); informing the physician of any health problems, current medications being taken, allergies to medications or anesthetics, and other health information; following post-operative instructions; and returning for a follow-up examination.

I have heard that women who have abortions regret their decision.

Few women take the decision to have an abortion lightly. However, researchers have found no connection between severe psychological disorders following an abortion and the procedure itself.

People who oppose abortion say it causes life-long damage.

Antiabortion activists claim that women who have abortions are more likely to become sterile, have difficulty conceiving again, develop ectopic (outside of the uterus) pregnancies, or deliver stillborn babies. However, according to the U.S. Centers for Disease Control, none of these claims is borne out by medical research.

Statistics for this Fact Sheet were derived from research by the U.S. Centers for Disease Control Abortion Surveillance Unit and The Alan Guttmacher Institute.

For Further Reading

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National Abortion Federation
900 Pennsylvania Avenue, S.E.
Washington, D.C. 20003
(202) 546-9060
November 1985

FACT SHEET

What Is Abortion?

Definition

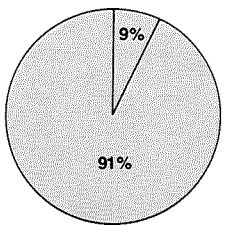
Technically, an abortion occurs whenever a fetus is expelled (forced out) before it is mature enough to be born. The fetus may be expelled spontaneously by the body (miscarriage) or deliberately as a result of a medical procedure (induced abortion). In common use, however, the word *abortion* is rarely used to describe miscarriage but refers to induced abortion, which is the subject of this fact sheet.

Methods

Physicians use two methods to induce abortions. The first, most common method is to open the cervix and remove the contents of the uterus (primarily the fetus and placenta). Most women obtain abortions during the first several weeks of pregnancy when it is easy to empty the uterus manually. For later abortions, the physician may induce the woman's body to begin labor early and to force the fetus and placenta out as in childbirth.

Determination of Stage of Pregnancy

The first step of any abortion is to determine that the woman is indeed pregnant and how far along her pregnancy is (how large the fetus is). Since the exact moment of conception is difficult to pinpoint, medical providers usually refer to the pregnancy in terms of the time that has passed since the last menstrual period (LMP). The woman is given a pregnancy test and examined internally (pelvic exam). Then, if the size of the fetus is in doubt, she may also be examined by ultrasound.



91% of all abortions are performed in the first trimester; only 9% after 13 weeks LMP.

First Trimester Pregnancy

If less than 13 weeks have passed since her last menstrual period, the woman is considered to be in the first trimester. By the end of the first trimester, the embryo has grown only to about the size of the first joint of an adult's thumb.

Actual size of first-trimester embryos

6 weeks **9 weeks** **12 weeks**

Technique for Early Abortions

The standard method for first-trimester abortions is *vacuum aspiration,* also called *suction curettage.* Most abortions in the U.S. are performed using this method.

Anesthetic. The woman lies on an examining table with her feet in stirrups. The doctor inserts a closed speculum into the vagina, then opens it to hold the vaginal walls apart. Occasionally there are medical reasons to put the woman to sleep briefly with a general anesthetic. However, most abortions are performed with a local anesthetic that numbs the cervix. Using a local anesthetic is both safer and less expensive.

Dilation. The physician gradually widens (dilates) the cervix in one of two ways. One way is to insert and remove rods, one at a time, gradually increasing the size of the rod until the opening is about the size of a drinking straw. Another method is to insert a sterile laminaria (seaweed) rod, which absorbs moisture from the cervix and gradually expands, thus enlarging the opening.

Aspiration and Curettage. The physician inserts a small tube (cannula) which is attached to an aspirator machine (similar to the one dentists use to clear the mouth of saliva). The machine's suction empties the contents of the uterus through the tube. Then the doctor carefully feels the walls of the uterus with a sharp, spoon-shaped instrument (curette) to be sure no tissue remains.

In all, the procedure usually takes about 10 minutes. Some women experience temporary pain — especially cramping — during and for up to an hour after the procedure. In addition, there may be some bleeding but no heavier than normal menstrual bleeding.

Complications from Early Abortion
Major problems resulting from early abortion occur in less than 1% of all cases. Serious problems are very rare. (For details, see *Fact Sheet: Safety of Abortion.)*

Techniques for Mid-trimester Abortions

From the 13th to about the 20th week, most abortions are performed using the dilatation and evacuation (D&E) method, some by inducing labor (induction). At this stage, it is more difficult to end the pregnancy because the fetus is larger and the placenta more firmly implanted.

D&E Method. Most mid-trimester abortions are performed by D&E, a procedure that requires considerable skill of the physician but is basically an expansion of the vacuum aspiration method described above. The cervix is anesthetized, then dilated. Depending on the method of dilation, the physician may proceed with the evacuation or wait several hours or overnight. To perform the abortion, the physician uses suction as in first-trimester procedures but also uses forceps to remove the fetal parts that are too large to pass through the suction tube. Finally, s/he checks the walls of the uterus with a curette. The procedure itself takes from 10 to 30 minutes. Both the dilation and the evacuation may be temporarily painful, and some women choose to use a pain medication to help them through.

Induction or Instillation Method. Less than 3% of all abortions in the U.S. are obtained by the induction method. Unlike the previously described out-patient methods, it is nearly always performed in a hospital and is the least safe, most expensive and most painful abortion procedure. The physician numbs the woman's abdomen and passes a long needle through it into the uterus. Through the needle, s/he withdraws a small amount of amniotic fluid and replaces it with a toxic substance — usually a salt (saline) solution, but sometimes prostaglandins. Some hours later, the patient goes into labor to expel the dead fetus.

Follow-up Care

Following an abortion, regardless of the method used, the woman waits in a recovery area where medical personnel can monitor her progress. Before she leaves, the medical personnel will give instructions for post-operative care, may give a prescription for antibiotic and/or other medications, and should schedule an appointment for the woman to return within 2-4 weeks. This follow-up visit is very important to make sure the abortion is complete and to discover and treat any problems that may have developed.

Statistics for this Fact Sheet were derived from research by the U.S. Centers for Disease Control Abortion Surveillance Unit and The Alan Guttmacher Institute.

For Further Reading

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comprehensive
health
associates

a member of the national abortion federation

POST-ABORTION CARE

Office phone: 913/345-1400
After hours phone: 913/345-1403

Consider the next two weeks your "special care" time. Throughout this period you may be bleeding or spotting. It is not unusual to have minimal bleeding or none at all right after your procedure and then to start a period-like flow a few days later; nor is it unusual to have a heavy flow beginning right after the procedure. Spotting or a light flow may persist as long as three weeks following your procedure.

Avoid remaining in one position for long periods of time. Be up at least 15 minutes each hour. If you must sit a lot, try to get some exercise during the day. If you must stand a lot, try to sit down during breaks or lunch with your feet up. You may resume normal, non-strenuous activity as soon as you feel comfortable doing so. Most women are able to go back to work immediately.

Infection and hemorrhage are possible complications after an abortion. You can help control these complications by using good judgment. Avoid any extreme physical exercise such as swimming, dancing, jogging, motorcycling, bowling or heavy lifting. Eat well. Avoid overtiring yourself. DO NOT HAVE VAGINAL INTERCOURSE, DOUCHE, OR USE TAMPONS. Change your pads frequently. Take showers rather than tub baths--that is, do not sit in a tub of water.

The doctor will give you a prescription for Tetracycline, an antibiotic which helps prevent infection. It is important that you take all the capsules. Take one pill four times daily one hour before or two hours after each meal and at bedtime until they are gone. Do not take with milk products or antacids because those milk products interfere with your absorption of the medicine. Tetracycline increases your skin's sensitivity to the sun and you can become sunburned very easily, so avoid prolonged exposure and use a good sunscreen. Should you develop any signs of an allergic reaction (hives, swelling, difficulty breathing), call us. These reactions could be due to the Tetracycline.

The doctor also may prescribe Methergine or ergonovine maleate for you. Take one tablet with each meal and one at bedtime until the medication is gone. This medication helps contract your uterus to its normal size and helps control bleeding. You may feel some mild cramping when you take it,but this should be relieved by aspirin or Tylenol.

The following symptoms indicate that you need further medical attention from us. Please call our regular office number (913/345-1400) if you experience these symptoms during one of our work days (Monday-Saturday). After hours and on Sunday, please call 913/345-1403. A doctor and a nurse are on call 24 hours a day to handle medical emergencies. If your after-hours call is not answered within 45 minutes, please call again and be sure that the answering service has your correct area code and phone number. Your call will be answered as quickly as possible.

1) excessive bleeding (more than is normal for you during a period, or more than one pad an hour), or excessive cramping not relieved by aspirin or Tylenol;

2) a fever of more than 100.4 degrees, or sudden exhaustion;

3) continued passing of large blood clots (larger than a lemon). It is not uncommon to pass small clots (quarter size), especially after sitting or lying for a long time.

4) a foul-smelling, yellow discharge. This most likely is a vaginal infection, meaning you should wait to call during regular office hours. However, if you have a temperature of 100.4 degrees or more, or if there is severe cramping with the discharge, call us immediately.

5) severe abdominal pain which is not relieved by normal pain remedies, walking, a heating pad, or massaging your uterus.

IF YOU CALL WITH A MEDICAL CONCERN, PLEASE TAKE YOUR TEMPERATURE FIRST AND HAVE A PHARMACY PHONE NUMBER AVAILABLE. THESE STEPS WILL SAVE TIME FOR YOU AND FOR US IN DEALING WITH YOUR CONCERNS. You can also help us and yourself by waiting until regular office hours to ask questions about appointments, medical problems that are not emergencies and birth control.

The first menstrual period following an abortion usually occurs 4-6 weeks after the procedure but may not occur for as long as 8 weeks. It is not unusual for the first period to be heavier than your normal period. If you do not have a menstrual period after 8 weeks, you need to call our office during regular office hours.

Two last points: 1) You can get pregnant immediately after an abortion. It is important to begin a reliable method of birth control now. If you are using birth control pills, be sure to start taking them on the Sunday following your procedure even if you are bleeding. Diaphragms can be fitted at your post-abortion checkup; IUDs can be inserted during your first post-abortion menstrual period.

2) It is not unusual to feel irritable, depressed or let down for the next week or two because of changes in the hormone levels in your body. If you feel concerned about emotional problems you are experiencing, please call us about those too, at our office number during office hours. We want you to call us if you need us.

POST-ABORTION CHECKUP: It is essential that you return to CHA or to your regular doctor for a checkup within ten days to three weeks from today to make sure that you are healing properly, that you are no longer pregnant and that you do not have an infection. YOUR ABORTION CARE IS NOT COMPLETE UNTIL YOU HAVE HAD THIS CHECKUP. If you go to your own doctor or practitioner for your checkup, you need another pregnancy test (a two-minute slide test) and a pelvic exam. You or your doctor should contact CHA if an abortion-related problem is discovered during your post-abortion checkup. Problems occurring after one month are more likely to not be related to your abortion procedure and should be managed by your own doctor or practitioner. If you wish, you may contact us and you will be followed as a gyn patient.

If you plan to return to your regular doctor, please tell the recovery room nurse so that she can give you a follow-up form to take with you when you leave. If you plan to return here, call for an appointment during the next two to three days. Our GYN schedule is fairly full so you need to call well in advance to be sure you can be seen. We have an evening clinic on Monday, scheduling our last patient at 6:30 p.m. The cost for the post-abortion checkup (PAC) for a first-trimester patient is $20. The PAC fee is included for laminaria patients. A PAC appointment plus a Pap smear costs $30. A PAC appointment plus a diaphragm fitting costs $40 or $42.

To make an appointment: call 913/345-1400 Monday-Friday 9:00-5:00; on Saturday call 9:00 a.m. - 3:00 p.m.

Take care. Please ask if you have questions about this information.

Testimony presented to the Committee on Federal and State Affairs
February 26, 1986
Senate Bill No. 577

Adele Hughey, Executive Director
Comprehensive Health Associates
4401 W. 109th
Overland Park, Kansas 66211
(a state licensed ambulatory surgical center)

We are opposed to Senate Bill No. 577 because of some of the basic assumptions that are being made and the consequences this Bill would have on teens in difficult life situations.

One assumption made is that all teens are from a complete and happy family unit and that abortion tears the family apart. However, if the love and communication is not there before, forcing a teen to go before a judge is not going to help the family.

Another assumption is that once the parent is aware of the pregnancy the parent will talk the teen out of the abortion decision. From our experience, parents have tried to force the teen to have an abortion, when the teen wants to continue the pregnancy. Whose decision is it then?

Another assumption made by this Bill is that teens are too immature to make the decision whether or not to terminate a pregnancy; however they are mature enough to have a baby and decide whether or not to keep the baby or relinquish it for adoption. All decisions are difficult and cannot be changed once made.

Another assumption made is that the abortion providers care little for their patients especially teens. I would like to explain briefly the information presented to all women considering abortion.

1) At the time a woman makes an appointment, a complete medical history is taken.

2) When the woman arrives, all patients must go through a counseling session. There are no more than 5 women in each group. Individual counseling is also available. Topics covered in the session are a) a complete explanation of the procedure, b) risks; the risks covered are death, uterine perforation, infection, the chance of an ectopic pregnancy, the possibility of sterility, hemorrhage, and allergic reactions to medications or anesthetics, c) an explanation, both verbal and written, of aftercare instructions, and d) discussion of the woman's decision-making process, how long has she known she was pregnant, who is her support, has she considered other options, and fetal development.

3) The patient is then seen by licensed doctors and nurses and the counselor remains with her through the procedure and spends time with her in the recovery room.

According to a former Women Exploited by Abortion (WEBA) member, who was a patient of ours recently, she was surprised at how well she was treated and at how much information she was given.

The consequences of Senate Bill 577 for some teens the requirement of both parents' signatures would be practically impossible. Requiring two signatures for a surgical procedure is not standard practice.

The consequences for teens if Senate Bill 577 is passed would cause further delay in the decision-making process for teens and cause more second trimester abortions or more teen parents.

TESTIMONY BEFORE SENATE FEDERAL AND STATE AFFAIRS

February 26, 1986

Melissa L. Ness LMSW
National Abortion Rights Action League Board of Directors
Washington, D.C.

I represent the National Abortion Rights Action League as a National Board Member. We are an organization dedicated to keeping abortion a safe, legal and accessible choice. To this end we oppose attempts to prohibit young women from terminating an unintended pregancy. I therefore speak in oppostion to SB 567 restricting a minor's access to abortion.

There are many issues surrounding the topic of abortion but none so sensitive or volatile as the issue before this committee. You are charged with making a decision having great impact on an extremely vulnerable population...adolescents, a group with few rights and remedies under our legal system and virtually no political voice.

Keeping that charge in mind I urge you to consider the following salient points in deciding on the defeat or passage of SB 567.

This is not a parental consent or parental notification bill. This is strictly an attempt to restrict a minor's access to a legal abortion. Your constituents probably perceive this bill as protecting their rights as parents to know when their child seeks to obtain an abortion. No one encourages adolescents to exclude their parents from the process. However, the court has recognized that some parents will not act in the best interests of the child. Judges, not parents are given absolute authority over whether a minor can get an abortion in this legislation. In addition, a parent's right to know pales in comparison to the adolescent's need to receive sound medical advice and assistance. In many states an adolescent may receive private medical care for V.D., drug treatment or mental health counseling.

Extreme medical complications and long term emotional effects from the abortion procedure tend to be exaggerated and are in fact in the minority. Although this medical procedure is coupled with a moral decision, it nevertheless is a medical procedure. In the vast majority of cases, especially when done in the first trimester, it is performed safely with no medical complication or lasting psychological trauma.

This bill will not improve family relations or communication. Ideally every teenager, girl or boy, would feel free to talk with his or her parents about issues and values relating to sex. If this were true, teenage sexual activity would probably be reduced. Those who did become pregnant would be able to talk over their options with their parents. In fact this is the case with many teenagers and parents.

There are many teenagers however, who do not have this type of relationship. They instead fear violent reprisal or some may even be victims of incest. When I was employed at the Mental Health Center of East Central Kansas in Emporia, I worked directly with victims of incest. Witnessing the trauma and agony of revealing the perpetrator of the crime was difficult enough. Imagine that situation with the trauma of an

addtional court hearing or trying to secure consent from parents who have already demonstrated their lack of capacity to parent.

NARAL strongly supports encouraging the pregnant minor to discuss her decision with her parents, school counselors or religious leaders. However, we do not feel we can legislate a good relationship.

If consent cannot be obtained from either parent, a system which mandates a judge's determination is unduly burdensome to the adolescent. Appearing before court is intimidating. That factor could push the decision of a minor to seek an abortion well into the second trimester where risk increases. Given the heavy case load of courts it is difficult to obtain an expedient hearing. Safeguards for confidentiality are virtually lost, especially in smaller towns and locales. The daily docket is news!

Judges may very well be placed in a position of deciding whether a minor is mature enough to decide to have an abortion. If a judge decides she is not mature enough does it then mean she is mature enough to be a mother?

Approximately 99% of the petitions coming before the court of this nature are granted. This is due largely in part to the fact it is 16 and 17 year olds who seek abortions. Does it make sense to delay the procedure for a formality when by and large 16 and 17 year olds tend to possess a greater maturity level than younger adolescents?

This bill is not a determination on the legality or illegality of abortion. That issue has been decided. Instead you must focus on the fundamental fairness of the bill. If you cannot clearly answer the question of what impact this would have on adolescents the bill should be defeated.

Lest you think I speak only as an observer of the abortion issue, like millions of other women I chose to have an abortion when a was barely 19 years old in January of 1973, the year of Roe v. Wade. I was fortunately met with compassion and assistance from my parents. I was put in touch with resources that presented all my options from adoption to abortion. I was under good sound medical care. Given that I struggled for a long time with the decision and as hard as that decision was, it is almost unimaginable to me to have gone through that decision without my parents support and love and instead a judge's scrutiny. My choice may have indeed been different. I cannot travel two paths but no one can convince me I would be in the position I am today had I not decided the way I did.
I have no regrets.

There is nothing wrong with laws that have a compelling state interest to protect a population but **only** if they are balanced with the rights of the individual. This bill does neither. It focuses only on the rights of the parents to the total exclusion of the problems it would create for adolescents.

There should be no urgency in the passage of this bill and would appeal to your legislative knowledge to proceed judiciously. It would seem more important to spend time developing legislation that would prevent the need for abortion.

Due to the nature of this bill I urge you not to pass it as it stands.

Testimony - Committee on Federal and State Affairs

Opposition to SB 577

February 26, 1986

Margo Smith
Director of Counseling
Comprehensive Health Associates
4401 W. 109 St.
Overland Park, Kansas 66211

My name is Margo Smith. I have a Master's Degree in Counseling and 11 years experience counseling women in first and second trimesters of pregnancy, about their problem pregnancies.

The counseling sessions at our clinic are approximately 1 to 1½ hours long and cover five very important topics: (1) explanation of the abortion procedure, (2) follow-up care, (3)explanation of the consent form and possible risks, (4) future birth control, and (5) the patient's decision to have an abortion. Counselors, at our facility, are particularly concerned that the patient is sure of her decision, and has not been pressured to have an abortion by family, friends, or partner. Counselors also ask patients if they have considered the alternative of adoption or keeping the baby, and why they feel abortion is a better option for them. Patients are also questioned about their ability to cope with a decision to have an abortion emotionally, and who is supportive among partner, friends or family members.

Many teenagers are able to tell one or both parents about their pregnancy, for financial and/or emotional support. In many of these instances, parents are supportive. However, parental knowledge of a teen's pregnancy does not always have a positive outcome.

A counselor at our clinic encouraged a minor in her first trimester of pregnancy to tell her parents since she needed money for the abortion. This teenage woman left the clinic, and after several hours, called our counselor to tell her that she had told her parents - they had beaten her and thrown her out of the house.

A nurse practitioner at our facility advised a minor in her second trimester of pregnancy to tell her father. She told her father - he beat her.

I counseled a 14-year old patient approximately 6 months ago, who told me she did not want an abortion, and that her mother was forcing her to have one. I informed the patient, and the patient's mother, that we could not do her abortion - the mother threatened to sue our clinic. Naturally, we did not perform the abortion.

Many teenage patients are victims of rape or incest, and do not want to tell their parents because they are convinced their parents will not be supportive, especially if another family member is involved in the pregnancy.

A 16-year old patient told our nurse practitioner that she was pregnant by her grandfather, and did not want to tell her mother, a psychologist, because she felt her mother would not be supportive. Many months after the abotion she did tell her mother, but only after the grandfather died.

A year ago, we saw a 12-year old patient, blind from cancer, who was pregnant by her stepbrother. She had reached her second trimester of pregnancy before her mother, noticing she had gained a great deal of weight, discovered her daughter was pregnant. Unable to get the abortion in Canada, they drove to Kansas City.

Many patients are convinced that their parents, if they knew they were pregnant, would try to prevent them from obtaining an abortion.

Yesterday, we saw 2 patients, both in their second trimester of pregnancy, who felt their parents would oppose the abortion. A 15-year old patient had been enc ouraged by her aunt, who was with her, to tell her parents. This patient was convinced that her parents would try to prevent the abortion because of their religious beliefs.

A 17-year old patient was also convinced her parents would oppose the abortion. Her 28-year old sister, who was with her, agreed and they both elected not to tell their parents.

Many teens have told me that their parents have threatened them with all kinds of possible punishments, if they have sex and get pregnant. Some parents have threatened to throw a pregnant daughter out of the house. Some parents have threatened to have the boyfriend arrested for statutory rape. Other teens have been told that their parents would put them in a "corrective institution." Some parents have threatened to disown their daughters or sons.

Some parents carry out such threats, and others are merely attempting to scare their teenage sons and daughters to prevent them from having six. Regardless of the parents' intent, teenagers believe these threats, and the outcome of such fears is that they often delay dealing with the pregnancy until they have reached the second or third trimester of pregnancy, and therefore, are ineligible for an abortion. Nothing is more heartbreaking for me then telling a teenage young woman and her parents that they must have a child none of them wants, and that their daughter, because she has not received any OB care, may have a high risk pregnancy.

TESTIMONY

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
FEBRUARY 26, 1986

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM BELVA OTT, PUBLIC AFFAIRS DIRECTOR FOR PLANNED PARENTHOOD OF KANSAS WITH OFFICES IN WICHITA, HAYS AND WINFIELD.

I AM GRAVELY CONCERNED BOTH AS A PARENT AND AS A PROFESSIONAL ABOUT THE HARMFUL CONSEQUENCES THAT WOULD MOST CERTAINLY RESULT FROM THE PASSAGE OF SB577 FOR THE YOUTH OF OUR STATE.

SB577 HAS AS ITS GOALS THE PROTECTION OF MINORS AGAINST THEIR IMMATURITY, FOSTERING THE FAMILY UNIT AND PROTECTING THE RIGHTS OF PARENTS TO REAR THEIR CHILDREN. THESE ARE LAUDABLE GOALS. AS PARENTS, WE ALL WANT TO SPARE OUR CHILDREN FROM MAKING MISTAKES AND PROTECTING THEM FROM DIFFICULT DECISIONS WHILE THEY ARE YOUNG. THIS IS NOT ALWAYS POSSIBLE. WE CAN HOPE THAT WE HAVE ESTABLISHED ENOUGH TRUST AND SUPPORT WITHIN OUR FAMILIES THAT OUR TEENAGERS WILL ASK FOR OUR HELP AS THEY FACE CRISIS AND DIFFICULT DECISIONS. WE CANNOT FORCE OUR TEENAGERS TO TRUST US, TO CONFIDE IN US AND TO ASK FOR OUR HELP. NO LAW CAN DO THAT FOR US EITHER.

WE NEED TO CONSIDER THE TEENAGER OR FAMILY WHO MAY FAIL IN ONE OF THE AREAS OF CONCERN? ARE ALL FAMILIES THE "IDEAL AMERICAN FAMILY?" I'M AFRAID NOT. SOME TEENS HAVE GROWN UP, AND ARE GROWING UP TODAY, IN HOMES WHERE THERE IS VIOLENCE, ABUSE AND INCEST. ARE YOU GOING TO RESTRICT THEIR ACCESS SO THAT THEIR ONLY OPTIONS ARE TO GO OUT OF STATE, SEEK AN ILLEGAL ABORTION, OR DELAY IN RECEIVING HELP. ALL OF THESE ARE EXTREMELY DETRIMENTAL TO THE VERY TEENAGERS HEALTH WHO WE ALL WANT TO HELP. I AM AWARE THAT THERE IS A COURT BYPASS PROCEDURE IN THE BILL. I DON'T KNOW HOW STRESSFUL IT IS FOR YOU TO GO TO COURT, BUT I IMAGINE THAT IT WOULD BE EXTREMELY STRESSFUL TO A TEENAGER. WHERE IS THE STATE'S INTEREST IN THE MINOR AT THIS POINT? YOUNG WOMEN WILL BE FACED WITH SCHOOL ABSENCE, HAVING TO FIND TRANSPORTATION TO TRAVEL POTENTIALLY LONG DISTANCES, RISKING BREACHES OF CONFIDENTIALITY AT EVERY TURN,

APPEARING BEFORE A JUDGE IN A VERY STRANGE AND STRESSFUL ENVIRONMENT AND BEING UNCERTAIN OF THE OUTCOME, WHICH WILL AFFECT HER LIFE FOREVER.

REMEMBER, IT IS THE YOUNG WOMAN WHO WILL BEAR THE RESPONSIBILITY FOR THE DECISION THAT IS BEING MADE FOR HER FOR HER LIFETIME----NO JUDGE, PARENT OR OTHER INDIVIDUAL CAN ASSURE HER SHE WILL HAVE SUPPORT FOR HER CHOICE THROUGHOUT HER LIFE. ARE WE TELLING HER THAT SHE IS TOO IMMATURE TO MAKE A DECISION THAT WILL AFFECT HER FOR HER ENTIRE LIFE, BUT SHE IS MATURE ENOUGH TO CONTINUE A PREGNANCY TO TERM, GO THROUGH THE DELIVERY AND BE RESPONSIBLE FOR BOTH HERSELF AND HER CHILD FOREVER. WILL ALL THOSE MAKING THE DECISION FOR HER CONTINUE TO SUPPORT HER, OR WILL SHE POSSIBLY BE ON HER OWN AFTER THE CHILD IS BORN? PERHAPS I SHOULD REMIND YOU, 96% OF TEENS WHO CONTINUE THEIR PREGNANCY KEEP THEIR BABY.

A POINT THAT SHOULD BE STRESSED IS THAT TEENS MAKE UP ONLY 10% OF THE INDIVIDUALS RECEIVING ABORTIONS IN THIS STATE. ALSO, 70-75% OF TEENS DO INVOLVE THEIR PARENTS IN A DECISION ABOUT PREGNANCY. THOSE WHO DON'T CITE REASONS SUCH AS:

---MAY BE VICTIMS OF ABUSE OR INCEST

---OFTEN ARE FROM DYSFUNCTIONAL HOMES

---FEEL PARENTS MAY BE PUNITIVE

THIS DOES HAPPEN. RECENTLY A CALL WAS TAKEN BY THE EXECUTIVE DIRECTOR OF PLANNED PARENTHOOD, PEGGY JARMAN, IN OUR WICHITA OFFICE. THE PARENTS OF A 16 YEAR OLD DAUGHTER CALLED. SHE HAD CONFIDED TO HER MOTHER THAT SHE WAS UNDER PRESSURE FROM HER COLLEGE FRESHMAN BOYFRIEND AND SHE WENT TO PLANNED PARENTHOOD FOR BITH CONTROL. THE MOTHER WAS DEVASTATED AND TOLD THE FATHER. THE FATHER WAS LIVID. HE CALLED HER A SLUT, A WHORE AND OTHER NAMES THAT CANNOT BE REPEATED----ALL HEARD IN THE BACKGROUND OVER THE PHONE WHILE THE MOTHER TALKED TO MS. JARMAN. THE FATHER SAID SHE WOULD NEVER BE ALLOWED BACK INTO HIS HOME. WHILE HE WAS RAGING IN THE BACKGROUND, THE MOTHER KEPT REPEATING WHAT A FINE CHRISTIAN HOME THE GIRL WAS RAISED IN. THE DAUGHTER HAD NOW RUN AWAY FROM HOME. WHAT WOULD HAVE HAPPENED IF THE GIRL HADN'T TRIED TO BE RESPONSIBLE BY GETTING BIRTH CONTROL HELP, BUT HAD BEEN FORCED TO TELL HER PARENTS SHE WAS PREGNANT? HER FATHER WAS THREATENING TO KILL HER IF HE EVER SAW HER AGAIN AND SHE HADN'T EVEN HAD A SEXUAL EXPERIENCE YET. HOW WILL THIS BILL IMPROVE FAMILY UNITY IN THIS HOME? IS IT GOING TO

ENHANCE COMMUNICATION WITHIN THIS FAMILY? TEENS INCLUDE PARENTS WHENEVER THEY CAN--SOMETIMES THEY JUST CAN'T.

LET'S LOOK AT THIS BILL JUST FROM A HEALTH ISSUE. CARRYING A PREGNANCY TO TERM IS AT LEAST 40 TIMES MORE DANGEROUS TO A WOMAN'S HEALTH THAN AN ABORTION WITHIN THE FIRST 9 WEEKS AND 10 TIMES MORE DANGEROUS THAN IN THE FIRST 12 WEEKS. THE RISK OF DEATH FROM AN ILLEGAL ABORTION IS 1 IN 3,000 COMPARED WITH 1 IN 400,000 FOR A LEGAL FIRST TRIMESTER ABORTION.

AT THE PRESENT TIME, MINORS IN KANSAS MAKE OTHER DECISIONS ABOUT THEIR REPRODUCTIVE HEALTH CARE WITHOUT PARENTAL CONSENT. IT IS PUBLIC POLICY. MINORS MAKE DECISIONS ABOUT PREGNANCY, PRENATAL CARE AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES. I KNOW THERE IS THE ARGUMENT MINORS CAN'T BE TREATED FOR EMERGENCIES OR GIVEN AN ASPIRIN IN SCHOOL WITHOUT PARENTAL CONSENT. THERE IS NO LAW THAT SAYS THE PROVIDER MUST GET PERMISSION. THIS IS LIKELY DONE FOR BOTH LIABILITY AND ECONOMIC REASONS, RELATING TO THE PROVIDER.

WHILE WE ALL RECOGNIZE THE SERIOUSNESS OF A DECISION TO TERMINATE A PREGNANCY, WE MUST CONSIDER THE ACTUAL RISKS THAT WILL BE FORCED ON THE TEEN BY DELAYING A YOUNG PREGNANT TEEN'S ENTRY INTO THE HEALTH CARE SYSTEM: CAUSING HER TO BECOME A PARENT BY DEFAULT, LITTLE OR NO PRENATAL CARE, NONEXISTENT FAMILY SUPPORT SYSTEMS OR FORCING HER TO SEEK A SECOND TRIMESTER ABORTION. IT'S POSSIBLE FOR HER PARENTS TO FORCE HER TO BEAR A CHILD OR FORCE HER TO CHOOSE ABORTION AGAINST HER WILL. THIS MUST BE A DECISION THAT IS MADE BY THE TEEN AS SHE IS THE ONE WHO MUST ACCEPT RESPONSIBILITY FOR THAT DECISION. ATTACHED IS A SHEET OF THE MEDICAL, SOCIAL AND ECONOMIC PROBLEMS RESULTING FROM TEEN PREGNANCY.

WHILE RECOGNIZING THAT BETTER COMMUNICATION BETWEEN PARENTS AND TEENS IS A LAUDABLE GOAL, THIS BILL HAS MANY PROBLEMS. WE BELIEVE IT IS RIFE WITH LEGAL INADEQUACIES; MANY OF THEM OF CONSTITUTIONAL DIMENSION. WE FEEL THE COMMITTEE SHOULDN'T PASS A BILL WHICH INFRINGES ON INDIVIDUAL MINORS RIGHT AS IT WOULD BE POOR PUBLIC POLICY. THE LEGISLATURE SHOULD NOT AND CANNOT BE IN THE BUSINESS OF PASSING LAWS WHICH AREN'T IN THE BEST INTEREST OF EVERY CITIZEN OF KANSAS. THE REAL TRUTH IS: YOU CANNOT LEGISLATE COMMUNICATION BETWEEN PERSONS. THIS IS AN ISSUE THAT MUST BE RESOLVED BY THE INDIVIDUAL MOST INVOLVED AND WHO WILL BEAR THE RESPONSIBILITY FOR THAT DECISION FOR A LIFETIME.

ATTACHMENT A

ACTUAL RISKS OF PREGNANCY AND CHILDBIRTH TO ADOLESCENTS: MEDICAL, SOCIAL, ECONOMIC

MEDICAL COMPLICATIONS:	THE YOUNGER THE MOTHER, THE MORE LIKELY THE BABY IS TO DIE. OF FETAL DEATHS, 20% WERE TO MOTHERS 19 AND UNDER. IN A KANSAS STUDY OF INFANT DEATH DUE TO SUSPECTED CASES OF CHILD ABUSE, OVER 90% OF THE PARENTS BEGAN PARENTHOOD AS TEENS.
SOCIAL IMPLICATIONS:	2/3 OF ALL TEEN PREGNANCIES ARE UNINTENDED. 96% OF TEEN MOTHERS KEEP THEIR BABIES AND DO NOT PLACE THEM FOR ADOPTION.
ECONOMIC IMPACT:	8 OUT OF 10 WOMEN WHO BECOME MOTHERS BEFORE THE AGE OF 17 OR YOUNGER NEVER FINISH SCHOOL. OVER 60% OF ALL TEENAGER MOTHERS ARE ON WELFARE.

TESTIMONY OF G. GORDON ATCHESON
REGARDING SENATE BILL NO. 577

I am a lawyer practicing in Wichita and a member of the Board of Directors of Planned Parenthood of Kansas, Inc. My testimony regarding Senate Bill No. 577 reflects that dual perspective. I will address certain fundamental legal questions posed and problems created by the bill. I will leave to others the debate regarding the medical, sociological and philosophical implications of this proposed legislation.

Commonly known as the "parental consent for abortion" bill, this proposal is of doubtful constitutionality. It infringes upon due process rights secured both through the U.S. Constitution and the Kansas Constitution. Further, it impermissibly intrudes upon the fundamental right to privacy that implicitly undergirds the freedoms guaranteed in the U.S. and Kansas Bills of Rights. The right to privacy is, perhaps, most precious and most closely guarded by the Courts in decision-making concerning reproductive freedom and family planning.

The law is clear: A woman, in consultation with her physician, may freely choose to use birth control or terminate an unwanted pregnancy. Those decisions ought not to be subjected to public scrutiny or comment; they are to be made in the sanctuary of a woman's heart and mind, based on her own religious or philisophical convictions. The government may not unduly burden or hinder that freedom to choose. Likewise, the powers of the state may not be brought to bear to prevent a woman from

effectuating her choice. Abortion is a legally and medically acceptable family planning option.

Ultimately parental consent laws of any type inhibit the freedom to choose and the right of privacy. As such, these laws represent poor public policy. They cannot fill the void created by inadequate sex education in the home, the schools and the community generally. These laws are more disruptive of family unity than their absence could ever be. But that is a matter separate from the legality of S. B. 577.

The government lawfully may not preclude women from obtaining abortions either by explicitly prohibiting physicians from performing such medical procedures or by establishing rules and requirements so onerous as to limit availability of abortion services as a practical matter. This is the constitutional deficiency of S. B. No. 577. It impermissibly limits access to abortion procedures for all women, but most particularly those under the age of 18.

Everyone agrees that ideally a woman under the age of 18 and living at home should feel able to consult with her parents before seeking medical care or undergoing surgery of any kind. Planned Parenthood is acutely aware of the benefits of discussion and harmonious decision-making within the family on matters of reproductive choice. Ideally, too, a woman exercising her right to have an abortion should be free from the emotional and, at times, actual physical pressures imposed by anti-choice zealots. Unfortunately, we do not live in an ideal world.

Legislation such as S. B. No. 577 only serves to exacerbate the already trying circumstances confronting a woman facing an unwanted pregnancy.

First, Section 7 of the bill creates a new crime called aggravated criminal abortion, making it unlawful to perform abortions after the first trimester anywhere other than in a licensed hospital or ambulatory surgical center. The maximum penalty for violating this proposed law would be 15 years to life in prison. The U.S. Supreme Court has repeatedly struck down as unconstitutional requirements that all abortions be performed in hospitals or similar "full service" medical facilities. See e.g., City of Akron vs. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983); Planned Parenthood Association of Kansas City, Missouri, Inc. vs. Ashcroft, 462 U.S. 476 (1983). Likewise, state-imposed limitations on the type of facilities in which second-trimester abortions can be performed must be narrowly designed to promote the health interests of the patient.

In this respect, limiting second trimester abortions to hospitals or ambulatory surgical centers, as opposed to other types of free-standing clinics, is constitutionally suspect. This is particularly so with respect to early second trimester abortions. Kansas administrative regulations pertaining to ambulatory surgical centers require them to have multiple-physician medical staffs, surgical advisory and community advisory committees, administrative governing boards, and methods for compiling and maintaining exhaustive statistical data on

patients, among other things. While this sort of regulation may be appropriate for facilities providing a broad range of surgical services, they would appear to be wholly inappropriate for free-standing clinics providing only specialized reproductive services such as abortions. Clearly, these provisions are in no way directly tied to the nature or quality of patient care. They do, however, add significantly to the overhead costs and consequently the patient fees for services.

Women in outlying rural areas of Kansas would have to travel significant distances to avail themselves of the services of a hospital or an ambulatory surgical center for early second trimester abortions. The U.S. Supreme Court has said that forcing women to travel in search of such "approved" facilities results in additional financial expense and health risk. Such increased health risks and financial burdens may pose impermissible limitations on a woman's ability to obtain an abortion. See, City of Akron vs. Akron Center for Reproductive Health.

A second significant constitutional defect in S. B. 577 involves the requirement that a woman under the age of 18 obtain parental consent for an abortion. The bill essentially dictates that a physician secure the consent of both parents unless the minor patient has obtained a District Court ruling waiving the consent requirement. A physician who performs an abortion without such consent or judicial decree may be charged with aggravated criminal abortion.

At the outset, it should be noted that minors possess fundamentally the same constitutional rights as adults. Therefore, the state may not grant parents an absolute veto over an unemancipated woman's choice to have an abortion. Similarly, neither the courts nor an unemancipated woman's parents may compel her to forego such an alternative to an unwanted pregnancy, if she is capable of making that choice for herself.

Thus, a pregnant young woman may face the emotionally debilitating alternatives of convincing potentially hostile parents to consent to her abortion or plunging into an unknown and mysterious judicial process to convince a complete stranger that she is "mature" enough to make such a decision.

If either parent refuses to consent or the young woman wishes to decide the matter on her own, she must subject herself to the judicial process outlined in S. B. 577. She must initiate the Court action by filing a Petition in the District Court of the county in which the abortion is sought. Requiring filing in that county rather than the county of the Petitioner's residence may itself be a constitutionally impermissible burden on the right of free choice. In Kansas, abortions are routinely available only in the population centers of Wichita and Kansas City. Young women in other areas would have to travel to those counties to file their Petition and attend the subsequent Court hearing. The attendant expense and health risk is not unlike that the Supreme Court has found to be impermissible with regard

to limitations on the type of medical facilities in which abortions may be performed.

The Petition must set out the Petitioner's initials her age, the address of her parents, and the reason she is seeking an abortion and the waiver of parental consent. S. B. 577 presumes apparently that the Petitioner has decided to have an abortion, although she might actually be seeking only a judicial determination that she has the right to decide one way or the other without involving her parents in that decision. Within ten days of the filing of the Petition, the District Court is to hear evidence concerning the young woman's "age, family, circumstances of pregnancy, gestation of the fetus, emotional and physical stability and development of the minor, the alternatives to the abortion considered by the minor, whether the minor's parents have consented, previous pregnancies and other matters which the Court considers useful ..."

By its very nature, such an inquiry will at best be acutely embarrassing and emotionally upsetting. The Court then must either find that the Petitioner is "mature and well-informed enough to make the abortion decision for herself" or that the abortion nonetheless should be performed in the best interests of the Petitioner. The U.S. Supreme Court clearly has suggested that the permissible determination by the Court is limited to the Petitioner's maturity to make the decision or whether the procedure is in her best interests. The amount of information then possessed by the Petitioner should not be determinative,

since she may later obtain whatever further information she desires.

Given the factors the Court is to consider, the Petitioner almost certainly will have to present not only a statement of her own reasons for securing the right to choose free from her parents knowledge and consent, but also expert medical and psychological testimony. Testimony from a treating physician will be necessary to establish such things as the Petitioner's physical stability and the gestation of the fetus. Further, the Court might well require a social worker, psychologist or psychiatrist to give testimony regarding the emotional stability and development of the Petitioner. The Petitioner herself would have to retain and pay these experts for their services in connection with the proceeding. It is the rare young woman who would have such financial resources. This, too, places a constitutionally questionable imposition on the free exercise of choice regarding abortion.

Even if the Court were to grant the Petitioner's request that she be permitted to make the decision concerning whether or not to have an abortion, the path is far from clear for implementation of that decision. This is, perhaps, the most pernicious aspect of S. B. 577. The treating physician is required to obtain prior written consent from the minor patient setting out the date of the Court order waiving parental consent, the case number and a statement that the minor has been informed of certain aspects of the medical procedure. The treating

physician, however, has no way of verifying that such an order has in fact been granted because the Court records are to be kept confidential. The confidentiality restrictions set out in the bill preclude the judge or the court clerk from releasing the order or any information about it to the treating physician.

Therefore, the treating physician must rely solely on the representations of the patient that such an order has indeed been entered. If there were no such order or the patient were mistaken about its contents, the treating physician would be subject to prosecution for aggravated criminal abortion as defined in Section 7 of the bill. Certainly the thought would have to cross a treating physician's mind that a young woman desperate to obtain an abortion and confronted with unyielding parents and an imposing Court system might fabricate the existence of such a Court order. Merely that possibility weighed against the potential penalties for aggravated criminal abortion proposed in S. B. 577 would deter most if not all physicians from proceeding.

It is not apparent whether this Catch 22 -- the physician faces criminal charges carrying a penalty of up to life in prison for performing an abortion on a minor without a Court order and yet is powerless to confirm the existence of such an order -- results from poor draftmanship or an insidious attempt to deny minors the right to obtain abortions without parental consent. In either case, this defect is of constitutional

magnitude and amounts to a clear deprivation of fundamental due process.

Similar, if less striking, unconstitutional denials of due process exist in the appellate procedures set out in S. B. 577. The District Court is required to rule on Petitioner's claim within ten days of its filing. If the District Court denies the Petition, the young woman may take an appeal to the Court of Appeals. The Clerk of the District Court is to forward the "official file" to the Court of Appeals within five days after the filing of the notice of appeal. The Court of Appeals is then to hold a hearing within ten days of the docketing of the appeal and shall issue an order five days after the hearing.

Thus, the minimum elapsed time from the filing of the Petition with the District Court through appellate review would be slightly more than four weeks. For most judicial matters this would be extraordinarily rapid. But in the case of a pregnant woman seeking an abortion, that time may be the difference between a relatively safe procedure and a relatively risky one. In certain instances, it may be the difference between having an abortion and being forced to carry an unwanted pregnancy to term. While the U.S. Supreme Court has not spelled out what time requirements pass constitutional muster, it has always recognized that time is of the essence with regard to free choice in abortion decisions. See e.g. Bellotti vs. Baird, 443 U.S. 662 (1979).

Further, the Court of Appeals would be required to rule based on the "official file", consisting only of the Petition, process, service of process, orders, writs and journal entries reflecting hearings held and judgments and decrees entered by the Court. See, K.S.A. 38-1506(a). The File would not include the transcripts of any hearings held. Thus, the Court of Appeals would be denied review of any testimony offered to the District Court judge in support of the young woman's Petition. Without a transcript of such testimony, the Court of Appeals could not reasonably make an independent determination as to whether or not the District Court acted soundly and within proper legal guidelines in denying the Petition. Therefore, the right of appeal afforded under S. B. 577 is in fact no appeal at all. This, too, is a denial of due process and renders the procedures unconstitutional.

There are other questions concerning whether or not portions of the bill are impermissibly vague, especially with respect to its penal provisions. Likewise, there is really no standard by which a judge is to determine if parental consent should be waived. Thus, results may vary dramatically from judge to judge in seemingly indistinguishable cases. These and similar deficiencies may also rise to a constitutional level.

In summary, Senate Bill No. 577 is rife with legal inadequacies; many of them are of constitutional dimension. If this bill were enacted, the Courts almost certainly would strike it down as unconstitutional. This proposed legislation

represents both poor public policy and lack of due regard for the fundamental rights of our state's citizens. The legislature should not and cannot be in the business of passing laws so at odds with the public's best interests.

Respectfully submitted,

G. GORDON ATCHESON

We Affirm

*American Baptist Churches, U.S.A.

General Board, 1981

Abortion presents us with a dilemma. It places in tension several of our historic commitments:

- Our commitment to the sanctity of human life.
- Our commitment to freedom of conscience and self-determination.
- Our commitment to the First Amendment guarantee of the free exercise of religion.

. . . Public law, enacted by human reason and enforced by state power, can never fully express the moral sensitivity of Christian love. We are therefore grateful for the Constitutional protection of religious freedom which guarantees our right to make personal moral decisions based on religious principles. The First Amendment affords each citizen freedom from the religious scruples of others and freedom to follow the religious dictates of conscience.

. . . We recognize that a human embryo is the physical beginning of a life which through a God-given process of development becomes a person. Choosing to terminate this developmental process is a crucial decision to be made only when all other possible alternatives will lead to greater destruction of human life and spirit.

. . . We recognize that Christian persons of sensitive and informed conscience find themselves on differing sides of the abortion issue. In our Baptist tradition the integrity of each person's conscience must be respected; therefore, we believe that abortion must be a matter of responsible, personal decision.

*American Ethical Union

Annual Assembly, 1973 (reaffirmed 1979)

The American Ethical Union wishes to express its disapproval of efforts to amend or circumvent the United States Constitution in such manner as would nullify or impede the decision of the United States Supreme Court regarding abortion.

We further believe that denial of Federal or State funds for abortion where they are provided for other medical services discriminates against poor women and abridges their freedom to act according to their conscience. The American Ethical Union supports the expansion of governmental family planning services as a means of reducing the need for abortion. (1979)

*American Ethical Union, National Service Conference

1976 (reaffirmed 1979)

We believe in the right of each individual to exercise his or her conscience; every woman has a civil and human right to determine whether or not to continue her pregnancy. We support the decision of the United States Supreme Court of January 22, 1973 regarding abortion.

We believe that no religious belief should be legislated into the legal structure of our country; the state must be neutral in all matters related to religious concepts. (1976)

American Friends Service Committee

1970

On religious, moral, and humanitarian grounds, therefore, we arrived at the view that it is far better to end an unwanted pregnancy than to encourage the evils resulting from forced pregnancy and childbirth. At the center of our position is a profound respect and reverence for human life, not only that of the potential human being who should never have been conceived, but that of the parent and the other children in the human community.

Believing that abortion should be subject to the same regulations and safeguards as those governing other medical and surgical procedures, we urge the repeal of all laws limiting either the circumstances under which a woman may have an abortion or the physician's freedom to use his or her best professional judgement in performing it.

*American Humanist Association

Annual Conference, 1977

We affirm the moral right of women to become pregnant by choice and to become mothers by choice. We affirm the moral right of women to freely choose a termination of unwanted pregnancies. We oppose actions by individuals, organizations and governmental bodies that attempt to restrict and limit the woman's moral right and obligation of responsible parenthood.

*American Jewish Congress

Biennial Convention, 1982

The American Jewish Congress has long recognized that reproductive freedom is a fundamental right, grounded in the most basic notions of personal privacy, individual integrity and religious liberty. Jewish religious traditions hold that a woman must be left to her own conscience and God to decide for herself what is morally correct. The fundamental right to privacy applies to contraception to avoid unintended pregnancy as well as to freedom of choice on abortion to prevent an unwanted birth.

In a climate of intensified efforts by the present Administration and by certain members of Congress to inject the government into these most personal decisions, we restate our opposition to any vehicle that would threaten a woman's access to abortion. We also reiterate our support for public funding of abortions so that the economically disadvantaged can exercise their right of choice along with the more affluent.

. . . The American Jewish Congress, therefore,

- Affirms its support for continuation of the national commitment to federally subsidized national family planning services;
- While encouraging parental involvement concerning family planning services for minors, opposes any efforts that would require parental notification or consent;
- Reaffirms its unwavering support for the Supreme Court decisions, including *Roe v. Wade* and *Doe v. Bolton*, which recognize that the Constitution guarantees women freedom of choice with respect to abortion;
- Reaffirms its opposition to all efforts—whether through Constitutional amendment, simple legislative fiat, or attacks on the jurisdiction of the courts—that would restrict or burden a woman's right to choose to terminate a pregnancy or that would compromise a physician's choice of treatment in the care of a pregnant woman for medical or surgical conditions which have no relationship to the pregnancy but which could adversely affect the fetus;
- Rejects all efforts to undermine the role of the judiciary and violate the principle of separation of powers with respect to reproductive freedom; and
- Rejects any efforts that would deny individual religious liberty to either clergy or lay people who, by virtue of their sincerely-held religious beliefs, may differ in interpreting when to attribute "personhood" to prenatal life.

American Protestant Health Association

1977

Voluntary abortion may be accepted as an option where all other possible alternatives may lead to greater distress of human life. Whenever pregnancy is interrupted by choice, there is a moral consequence because life is a gift. To this end, counseling resources should be available through medical centers to both individuals and families considering this alternative.

Circumstances which may lead to choosing to interrupt a pregnancy include medical indications of physical or mental deformity or disease, conception as a result of rape or incest, and a variety of social, psychological or economic conditions where the physical or mental health of either the mother or child would be seriously threatened. All reasonable efforts should be made to remove economic barriers which would prohibit the exercise of this option.

*B'nai B'rith Women

Biennial Convention, 1976 (reaffirmed 1978)

Although we recognize there is a great diversity of opinion on the issue of abortion, we also underscore the fact that every woman should have the legal choice with respect to abortion consistent with sound medical practice and in accordance with her conscience.

We wholeheartedly support the concepts of individual freedom of conscience and choice in the matter of abortion. Any Constitutional amendment prohibiting abortion would deny to the population at large their basic rights to follow their own teachings and attitudes on this subject which would threaten First Amendment rights. Additionally, legislation designed to ban federal funding for health facilities for abortions is discriminatory, since it would affect disadvantaged women, who have no access to expensive private institutions.

*Catholics For A Free Choice

1975

We affirm the religious liberty of Catholic women and men and those of other religions to make decisions regarding their own fertility free from church or governmental intervention in accordance with their own individual conscience.

Central Conference of American Rabbis

Annual Convention, 1975

We believe that in any decision whether or not to terminate a pregnancy, the individual family or woman must weigh the tradition as they struggle to formulate their own religious and moral criteria to reach their own personal decision. . . . We believe that the proper locus for formulating these religious and moral criteria and for making this decision must be the individual family or woman and not the state or other external agency.

. . . As we would not impose the historic position of Jewish teaching upon individuals nor legislate it as normative for society at large, so we would not wish the position of any other group imposed upon the Jewish community or the general population.

. . . We affirm the legal right of a family or a woman to determine on the basis of its or her own religious moral values whether or not to terminate a particular pregnancy. We oppose all Constitutional amendments that would abridge or circumscribe this right.

Central Conference of American Rabbis

Annual Convention, 1984

WHEREAS the so-called Hyde Amendment restricts the use of Medicaid funds for abortion; and other amendments have had a similar effect in other federal programs, so that a woman dependent on government health care cannot obtain a medically necessary abortion even if she is the victim of rape or incest or if her health is seriously jeopardized by continuation of the pregnancy; and

WHEREAS these restrictions have created greater health risks for poor women who have conscientiously chosen abortion but must delay the procedure while seeking private funds to pay for it,

THEREFORE BE IT RESOLVED that:

- The Central Conference of American Rabbis calls upon the Congress to defeat the Hyde Amendment this year, and
- The Central Conference of American Rabbis supports the Fazio-Green legislation which would eliminate such restrictions in the authorization for all federal governmental programs.

*Christian Church (Disciples of Christ)

General Assembly, 1975

WHEREAS, the Christian Church (Disciples of Christ) has proclaimed that in Christ, God affirms freedom and responsibility for individuals, and

WHEREAS, legislation is being introduced into the U.S. Congress which would embody in law one particular opinion concerning the morality of abortion . . .

THEREFORE BE IT RESOLVED, that the General Assembly of the Christian Church (Disciples of Christ) . . .

- Affirm the principle of individual liberty, freedom of individual conscience, and sacredness of life for all persons.
- Respect differences in religious beliefs concerning abortion and oppose, in accord with the principle of religious liberty, any attempt to legislate a specific religious opinion or belief concerning abortion upon all Americans.
- Provide through ministry of the local congregation, pastoral concern, and nurture of persons faced with the responsibility and trauma surrounding undesired pregnancy.

Episcopal Church (The)

General Convention, 1982

RESOLVED:

- The beginning of new human life, because it is a gift of the power of God's love for his people, and thereby sacred, should not and must not be undertaken unadvisedly or lightly but in full accordance of the understanding for which this power to conceive and give birth is bestowed by God.
- Such understanding includes the responsibility for Christians to limit the size of their families and to practice responsible birth control. Such means for moral limitations do not include abortion for convenience.
- The position of this Church, stated at the 62nd General Convention of the Church in Seattle in 1967, which declared support for the "termination of pregnancy" particularly in those cases where "the physical or mental health of the mother is threatened seriously, or where there is substantial reason to believe that the child would be born badly deformed in mind or body, or where the pregnancy has resulted from rape or incest" is reaffirmed. Termination of pregnancy for these reasons is permissible.
- In those cases where it is firmly and deeply believed by the person or persons concerned that pregnancy should be terminated for causes other than the above, members of this Church are urged to seek the advice and counsel of a Priest of this Church, and, where appropriate, penance.
- Whenever members of this Church are consulted with regard to proposed termination of pregnancy, they are to explore, with the person or persons seeking advice and counsel, other preferable courses of action.
- The Episcopal Church expresses its unequivocal opposition to any legislation on the part of the national or state governments which would abridge or deny the right of individuals to reach informed decisions in this matter and to act upon them.

*Episcopal Women's Caucus

Annual Meeting, 1978

We are deeply disturbed over the increasingly bitter and divisive battle being waged in legislative bodies to force continuance of unwanted pregnancies and to limit an American woman's right to abortion.

We believe that all should be free to exercise their own consciences on this matter and that where widely differing views are held by substantial sections of the American religious community, the particular belief of one religious body should not be forced on those who believe otherwise.

To prohibit or severely limit the use of public funds to pay for abortions abridges and denies the right to an abortion and discriminates especially against low income, young and minority women.

*Federation of Reconstructionist Congregations and Havurot

1981

Although the Jewish tradition regards children as a blessing, a gift of life itself, the tradition permits the abortion of an unborn child in order to safeguard the life and physical and mental health of the mother. The rabbis did not take a consistent stand on the question of whether a fetus resembles "a person." They did not think it possible to arrive at a final theoretical answer to the question of abortion, for that would mean nothing less than to be able to define convincingly what it means to be human.

We recognize that abortion is a tragic choice. Any prospective parent must make an agonizing decision between competing claims—the fetus, health, the need to support oneself and one's family, the need for time for a marriage to stabilize, responsibility for other children and the like. Some of us

consider abortion to be immoral except under the most extraordinary circumstances. Yet we all empathize with the anguish of those who must make the decision to abort or not to abort.

Lutheran Church in America

Biennial Convention, 1970 (reaffirmed 1978)

In the consideration of induced abortion the key issue is the status of the unborn fetus. Since the fetus is the organic beginning of human life, the termination of its development is always a serious matter. Nevertheless, a qualitative distinction must be made between its claims and the rights of a responsible person made in God's image who is in living relationships with God and other human beings. This understanding of responsible personhood is congruent with the historical Lutheran teaching and practice whereby only living persons are baptized.

On the basis of the evangelical ethic, a woman or couple may decide responsibly to seek an abortion. Earnest consideration should be given to the life and total health of the mother, her responsibilities to others in her family, the stage of development of the fetus, the economic and psychological stability of the home, the laws of the land, and the consequences for society as a whole.

Persons considering abortion are encouraged to consult with their physicians and spiritual counselors. This church upholds its pastors and other responsible counselors, and persons who conscientiously make decisions about abortion.

(T)he social statement opposes abortion on demand, since many factors must be considered in the decision. . . (T)he statement opposes the use of abortion as an alternative form of contraception. (1978)

*National Council of Jewish Women

National Convention, 1969 (reaffirmed 1979, 1982)

The members of NCJW reaffirm the strong commitment "to work to protect every woman's individual right to choose abortion and to eliminate any obstacles that would limit her reproductive freedom."

We believe that those who would legislate to deny freedom of choice compound the problems confronting women who are already condemned by poverty. It is therefore essential that federal and state funding be made available to women in need who choose abortion, just as such funding is available for other medical procedures.

We decry the fact that poor and young women must bear the major brunt of anti-abortion rights measures, and call upon all public officials to support and protect the right of every American woman to choose or reject the act of childbearing. (1979)

*National Federation of Temple Sisterhoods

Biennial Assembly, 1975

NFTS affirms our strong support for the right of a woman to obtain a legal abortion, under conditions now outlined in the 1973 decision of the United States Supreme Court. The Court's position established that during the first two trimesters, the private and personal decision of whether or not to continue to term an unwanted pregnancy should remain a matter of choice for the woman; she alone can exercise her ethical and religious judgement in this decision. Only by vigorously supporting this individual right to choose can we also ensure that every woman may act according to the religious and ethical tenets to which she adheres.

*North American Federation of Temple Youth

1981

BE IT RESOLVED

- That NFTY continue to strongly support the right of a woman to choose to obtain a safe, legal abortion, and
- That NFTY oppose any Contitutional amendment that could lead to the restriction of that right.

*Pioneer Women/NA'AMAT

Biennial Convention, 1983

Reproductive choice must be recognized as a matter of individual conscience outside the realm of government intrusion. We oppose attempts—whether by Constitutional amendment, legislation, judicial review or government regulation—to restrict women's access to safe and legal abortion, to bar financial assistance to women seeking abortion or to violate the confidentiality of family planning services.

We welcome decisions of the Supreme Court and other branches of the federal judiciary upholding women's rights: particularly opinions barring restrictions on women's right to abortion, and rulings against sex discrimination in employer-sponsored retirement plans and upholding the privacy of federally-funded family planning centers.

We must remain alert to defeat efforts in Congress to undermine the jurisdiction of federal courts on Constitutional matters relating to moral and social questions.

*Presbyterian Church, U.S.A.

General Assembly, 1983

Any decision for an abortion should be made as early as possible, generally within the first trimester of pregnancy, for reasons of the woman's health and safety. Abortions later in pregnancy are an option particularly in the case of women of menopausal age who do not discover they are pregnant until the second trimester, women who discover through fetal diagnosis that they are carrying a fetus with a grave genetic disorder, or women who did not seek or have access to medical care during the first trimester. At the point of fetal viability the responsibilities set before us in regard to the fetus begin to shift. Prior to viability, human responsibility is stewardship of life-in-development under the guidance of the Holy Spirit. Once the fetus is viable, its potential for physically autonomous human life means that the principle of inviolability can be applied.

. . . It is a tragic sign of the church's sinfulness that our propensity to judge rather than stand with persons making such decisions too often means that persons in need must bear the

additional burden of isolation. It would be far better if the person concerned could experience the strength that comes from shared sensitivity and caring. The church is called to be the loving and supportive community within whose life persons can best make decisions in conformity with God's purposes revealed in Jesus Christ.

. . . The church's position on public policy concerning abortion should reflect respect for other religious traditions and advocacy for full exercise of religious liberty. The Presbyterian Church exists within a very pluralistic environment. Its own members hold a variety of views. It is exactly this pluralism of beliefs which lead us to the conviction that the decision regarding abortion must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference.

Consequently, we have a responsibility to work to maintain a public policy of elective abortion, regulated by the health code, not the criminal code. The legal right to have an abortion is a necessary prerequisite to the exercise of conscience in abortion decisions. Legally speaking, abortion should be a woman's right because, theologically speaking, making a decision about abortion is, above all, her responsibility.

As Presbyterians and U.S. citizens we have a responsibility to guarantee every woman the freedom of reproductive choice. We affirm the intent of existing law in the United States regarding abortion: protecting the pregnant woman. Medical intervention should be made available to all who desire and qualify for it, not just to those who can afford preferential treatment.

. . . Thus the 195th General Assembly (1983):

- Urges Presbyterian congregations and their individual members to:
  - Provide a supportive community in which such decisions can be made in a setting of care and concern.
  - Respect the difficulty of making such decisions.
  - Affirm women's ability to make responsible decisions, whether the choice be to abort or to carry the pregnancy to term.
  - Protect the privacy of individuals involved in contraception and abortion decisions.
- Affirms the church's commitment to minimize the incidence of abortion and encourages sexuality education and the use of contraception to avoid unintentional pregnancies, while while recognizing that contraceptives are not absolutely effective...
- Recognizes that negative social attitudes toward women cast doubt on women's ability to make moral decisions and urges ministers and congregations to work to counter these underlying social attitudes and affirm the dignity of women.
- Recognizes that children may be born who are either unwanted or seriously handicapped and affirms the church's ongoing responsibility to provide supportive services to families in these situations and to help find appropriate institutional care and adoptive services where needed.
- Affirms the 1973 *Roe v. Wade* decision of the Supreme Court which decriminalized abortion during the first two trimesters of pregnancy. . . .
- Urges the Presbyterian Church . . . to model the just and compassionate community by:
  - Opposing adoption of all measures which would serve to restrict full and equal access to contraception and abortion services to all women, regardless of race, age, and economic standing.
  - Working actively to restore public funding by federal, state, and local governments for the availability of a full range of reproductive health services for the medically indigent. . .
  - Providing continuing support for women who, having made an abortion decision, may have doubts as to the wisdom of their choice, or having delivered a child are not able to cope with the separation of adoption or the responsibilities of child care.

Reorganized Church of Jesus Christ of Latter Day Saints

1974 (reaffirmed 1980)

We affirm that parenthood is partnership with God in the creative processes of the universe.

We affirm the necessity for parents to make responsible decisions regarding the conception and nurture of their children.

We affirm a profound regard for the personhood of the woman in her emotional, mental, and physical health; we also affirm a profound regard and concern for the potential of the unborn fetus.

We affirm the inadequacy of simplistic answers that regard all abortions as murder, or, on the other hand, regard abortion only as a medical procedure without moral significance.

We affirm the right of the woman to make her own decision regarding the continuation or termination of problem pregnancies. Preferably, this decision should be made in cooperation with her companion and in consultation with a physician, qualified minister, or professional counselor . . .

We affirm the need for skilled counselors being accessible to the membership of the church to assist persons in their struggle with issues centering in human sexuality, responsible parenthood, and wholeness of family life.

*Union of American Hebrew Congregations

Biennial Convention, 1975 (reaffirmed 1981)

The UAHC reaffirms its strong support for the right of a woman to obtain a legal abortion on the Constitutional grounds enunciated by the Supreme Court in its 1973 decision. . . This rule is a sound and enlightened position on this sensitive and difficult issue, and we express our confidence in the ability of the woman to exercise her ethical and religious judgment in making her decision.

The Supreme Court held that the question of when life begins is a matter of religious belief and not medical or legal fact. While recognizing the right of religious groups whose beliefs differ from ours to follow the dictates of their faith in this matter, we vigorously oppose the attempts to legislate particular beliefs of those groups into the law which governs us all. This is

a clear violation of the First Amendment. Furthermore, it may undermine the development of interfaith activities. Mutual respect and tolerance must remain the foundation of interreligious relations.

We oppose those riders and amendments to other bills aimed at halting Medicaid, legal counseling and family services in abortion-related activities. These restrictions severely discriminate against and penalize the poor who rely on governmental assistance to obtain the proper medical care to which they are legally entitled, including abortion.

We are opposed to attempts to restrict the right to abortion through Constitutional amendments. To establish in the Constitution the view of certain religious groups on the beginning of life has legal implications far beyond the question of abortion. Such amendments would undermine Constitutional liberties which protect all Americans.

*Unitarian Universalist Association

General Assembly, 1978

WHEREAS, religious freedom under the Bill of Rights is a cherished American right; and

WHEREAS, right to choice on contraception and abortion are important aspects to the right of privacy, respect for human life and freedom of conscience of women and their families; and

WHEREAS, there is increasing religious and political pressure in the United States to deny the foregoing right;

BE IT RESOLVED:

- That the 1978 General Assembly of the Unitarian Universalist Association once again affirms the 1973 decision of the Supreme Court of the United States on abortion and urges the Association and the member societies and individual members of member societies to continue and to intensify efforts to insure that every woman, whatever her financial means shall have the right to choose to terminate a pregnancy legally and with all possible safeguards; and
- That the 1978 General Assembly of the Unitarian Universalist Association urges the Unitarian Universalist Association, districts, and individual Unitarian Universalist societies to continue and, where possible, increase their efforts to maintain right of choice on abortion . . . ; and
- That the 1978 General Assembly of the Unitarian Universalist Association strongly opposes any denial or restriction of federal funds, or any Constitutional amendment, or the calling of a national Constitutional Convention to propose a Constitutional amendment that would prohibit or restrict access to legal abortion.

*Unitarian Universalist Women's Federation

Biennial Convention, 1975 (reaffirmed 1979, 1981)

The Unitarian Universalist Women's Federation reaffirm(s) the right of any woman of any age or marital or economic status to have an abortion at her own request upon consultation with her physician and urges all Unitarian Universalists in the United States and all Unitarian Universalist societies in the United States to resist through their elected representatives the efforts now under way by some members of the Congress of the United States to curtail their right by means of a Constitutional amendment or other means.

*United Church of Christ

General Synod, 1981

The question of when life (personhood) begins is basic to the abortion debate. It is primarily a theological question, on which denominations or religious groups must be permitted to establish and follow their own teachings.

Every woman must have the freedom of choice to follow her personal religious and moral convictions concerning the completion or termination of her pregnancy. The church as a caring community should provide counseling services and support for those women with both wanted and unwanted pregnancies to assist them in exploring all alternatives.

Freedom of Choice legislation must be passed at both the federal and state levels to provide the funds necessary to insure that all women, including the poor, have access to family planning assistance and safe, legal abortions performed by licensed physicians.

*United Methodist Church

General Conference, 1976, 1984

The beginning of life and the ending of life are the God-given boundaries of human existence. While individuals have always had some degree of control over when they would die, they now have the awesome power to determine when, and even whether, new individuals will be born. Our belief in the sanctity of unborn human life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of life and well-being of the mother for whom devastating damage may result from an unacceptable pregnancy. In continuity with past Christian teaching, we recognize tragic conflicts of life with life that may justify abortion, and in such cases support the legal option of abortion under proper medical procedures. We call all Christians to a searching and prayerful inquiry into the sorts of conditions that may warrant abortion. Governmental laws and regulations do not provide all the guidance required by the informed Christian conscience. Therefore a decision concerning abortion should be made only after thoughtful and prayerful consideration by the parties involved, with medical, pastoral, and other appropriate counsel. — *Social Principles, 1984*

When an unacceptable pregnancy occurs, a family, and most of all the pregnant woman, is confronted with the need to make a difficult decision. We believe that continuance of a pregnancy which endangers the life or health of the mother, or poses other serious problems concerning the life, health, or mental capability of the child to be, is not a moral necessity. In such a case, we believe the path of mature Christian judgement may indicate the advisability of abortion. We support the legal right to abortion as established by the 1973 Supreme Court decisions. We encourage women in counsel with husbands, doctors, and pastors to make their own responsible decisions concerning the personal or moral questions surrounding the issue of abortion. — *Resolution on Responsible Parenthood, 1976*

United Methodist Church, National Youth Ministry Organization

Biennial Convocation, 1983

One of the greatest and most divisive social issues battles of our time is being waged in the halls of government and in special interest elections campaigns.

Freedom of choice in problem pregnancies must be based on the moral judgment of the involved individuals.

Where there is no consistent medical, ethical, or theological consensus, the U.S. Constitution should not be used to force one theological view on all citizens who may believe otherwise.

Human Life Amendments to the U.S. Constitution or U.S. statutes which state that full human personhood begins at conception and that (an) embryo newly formed must be protected as a human person deny the religious freedom of those with differing views.

The U.S. Supreme Court decision of *Roe v. Wade* in 1973 guarantees a woman the right to make a personal decision regarding termination of a pregnancy. Any amendment to deconstitutionalize the issue of abortion and invalidate the 1973 decision could set a precedent for endangering all our civil liberties . . .

As the National Youth Ministry Convocation:

- We affirm our Social Principles statement on abortion. (See above.)
- We affirm safeguarding the U.S. Supreme Court decision that allows legal, medically safe abortions for women.
- We recognize each woman's individual freedom of choice but we deplore abortion as a means of birth control.
- We affirm the necessity for responsible decision-making in human sexuality and parenting.

*United Synagogue of America

Biennial Convention, 1975

"In all cases 'the mother's life takes precedence over that of the foetus' up to the minute of birth. This is to us an unequivocal principle. A threat to her basic health is moreover equated with a threat to her life. To go a step further, a classical responsum places danger to one's psychological health, when well established, on an equal footing with a threat to one's physical health." — 1967

(A)bortions, "though serious even in the early stages of conception, are not to be equated with murder, hardly more than is the decision not to become pregnant."

The United Synagogue affirms once again its position that "abortions involve very serious psychological, religious, and moral problems, but the welfare of the mother must always be our primary concern" and urges its congregations to oppose any legislative attempts to weaken the force of the Supreme Court's (1973) decisions through Constitutional amendments or through the deprivation of Medicaid, family services and other current welfare services in cases relating to abortion.

Women of the Episcopal Church

Triennial Meeting, 1973

WHEREAS the Church stands for the exercise of freedom of conscience by all and is required to fight for the right of everyone to execise that conscience,

THEREFORE, BE IT RESOLVED that the decision of the U.S. Supreme Court allowing women to exercise their conscience in the matter of abortion be endorsed by the Church.

*Women's League for Conservative Judaism

Biennial Convention, 1974

National Women's League believes that freedom of choice as to birth control and abortion is inherent in the civil rights of women.

We believe that all laws infringing on these rights should be repealed, and we urge our Sisterhoods to work for the implementation of this goal.

*Young Women's Christian Association of the U.S.A.

National Convention, 1973 (reaffirmed 1979, 1982)

In line with our Christian Purpose we, in the YWCA, affirm that a highly ethical stance is one that has concern for the quality of life of the living as well as for the potential for life. We believe that a woman also has a fundamental, Constitutional right to determine, along with her personal physician, the number and spacing of her children. Our decision does not mean that we advocate abortion as the most desirable solution to the problem, but rather that a woman should have the right to make the decision.

***We Affirm** represents excerpts from statements about abortion rights as expressed by national religious organizations.*

**Denotes membership in the Religious Coalition for Abortion Rights.*

Members of the Religious Coalition For Abortion Rights

~~National Ministries~~
~~American Baptist Churches, U.S.A.~~

American Ethical Union

National Service Conference
American Ethical Union

American Humanist Association

American Jewish Congress

B'nai B'rith Women

Catholics for a Free Choice

Womaen's Caucus
Church of the Brethren

Division of Homeland Ministries
Christian Church (Disciples of Christ)

Episcopal Urban Caucus

Episcopal Women's Caucus

Federation of Reconstructionist
Congregations and Havurot

National Council of Jewish Women

National Federation of Temple Sisterhoods

North American Federation of Temple Youth

Pioneer Women/NA'AMAT

Committee on Women's Concerns
Presbyterian Church (U.S.A.)

Council on Women and the Church
Presbyterian Church (U.S.A.)

General Assembly Mission Board
Presbyterian Church (U.S.A.)

The Program Agency
Presbyterian Church (U.S.A.)

Union of American Hebrew Congregations

Unitarian Universalist Association

Unitarian Universalist Women's Federation

Board for Homeland Ministries
United Church of Christ

Coordinating Center for Women
United Church of Christ

Office for Church in Society
United Church of Christ

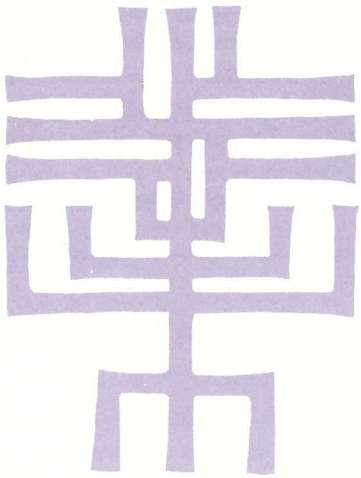
Board of Church and Society
United Methodist Church

Women's Division
Board of Global Ministries
United Methodist Church

United Synagogue of America

Women's League for Conservative Judaism

YWCA National Board



The logo of the Religious Coalition for Abortion Rights combines the symbols of two great religions. The Christian cross is made up of many branches rather than two strokes to represent the many sects of Christianity. Its lower branch is part of a menorah, symbol of the Old Testament, representing both the Jewish faith and the roots of Christianity. Resting on the base of three vertical bars (ancient symbol of an active intellect), the cross and menorah are intertwined to demonstrate the unity of purpose of the Coalition.

RELIGIOUS COALITION FOR ABORTION RIGHTS EDUCATIONAL FUND
100 Maryland Avenue, NE
Washington, DC 20002
202/543-7032

10/84

For some children the bedtime story is just the beginning of a nightmare.

"Once upon a time" is how most bedtime stories begin.

They lead children through a fairy tale world which ends "happily ever after." Unfortunately, grim reality prevents thousands of children from sharing this world of make believe.

INCEST

Despite a recent increase in awareness, child sexual abuse, and especially incest, is still "the silent crime"—its effects remain misunderstood and often unknown.

ALMOST 100,000 CHILDREN WERE REPORTED VICTIMS OF CHILD SEXUAL ABUSE AND INCEST IN 1982. The National Center on Child Abuse and Neglect (NCCAN) of the Department of Health and Human Services estimates that in 1982, 65,000 cases of child sexual abuse were officially reported to child protection service agencies throughout the nation. These cases involved as many as 98,000 children.[1]

INCEST IS A GROSSLY UNDERREPORTED CRIME. The victims themselves often do not report the crime "because of ignorance, fear of reprisals by the perpetrator, (and) fear that their parents will blame them."[2] In the case of incestuous relationships, other family members may be aware of the abuse, but do not bring it to the attention of the authorities "for fear of social censure, public scrutiny, and removal of the family breadwinner."[2] For these reasons, the reported cases of child sexual abuse and incest represent only "the tip of an unfathomable iceberg."

ANYWHERE FROM 9% TO 52% OF WOMEN AND 3% TO 9% OF MEN WERE SEXUALLY VICTIMIZED AS CHILDREN. Although studies differ in the percentages they obtain, they all reveal that child sexual abuse is a major and prevalent social problem.

THE MAJORITY OF VICTIMS ARE ABUSED BY FAMILY MEMBERS AND FRIENDS, NOT STRANGERS. A study conducted by David Finkelhor of the Family Violence Research Program of the University of New Hampshire found that "75% of the experiences reported were with older persons known to the child. Forty-four percent were with family members, including uncles, grandfathers, brothers-in-law, fathers and brothers. Twenty-two percent were within the nuclear family, and 6 percent were with fathers and stepfathers."[3]

Since the perpetrator is usually a nonstranger, he can often have frequent access to the child. This means that the abuse can occur repeatedly and over a long period of time.

CHILDREN FROM LOWER INCOME FAMILIES ARE MORE OFTEN VICTIMS OF SEXUAL ABUSE. In Finkelhor's study, girls from families with incomes of less than $10,000 were two thirds more likely to be victimized than the average girl.

PREGNANCY CAN AND DOES OCCUR FROM INCEST AND OTHER FORMS OF CHILD SEXUAL ABUSE. An act of unprotected intercourse results in pregnancy about 4% of the time. But incestuous relationships involve repeated abuse and often repeated acts of intercourse. This frequency of abuse makes pregnancy much more likely. In a study of 237 female victims of sexual abuse, 12% became pregnant.[4] 19% of the child victims in a 1963 sample became pregnant.[5]

Religious Coalition for Abortion Rights

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RAPE

THE NUMBER OF RAPES REPORTED IN THE UNITED STATES IN 1982 REACHED 77,763. According to the FBI, approximately out of every 100,000 women in the country were reported rape victims in 1982.[6]

THESE STATISTICS DO NOT EVEN BEGIN TO REFLECT HOW PREVALENT RAPE IS. Whether through fear of reprisals, shame or isolation, many rape victims do not report the crime to the authorities. Victims may also dread the possibility that their trauma might be compounded by the unwanted intrusion and sensationalism of a rape trial.

According to Dr. Menachem Amir's study, between 50% and 95% of rapes go unreported.[7] A study of rape in San Francisco found that only one in 23 rapes in that city were reported to the police.[8] It has been estimated that rape is so common that one in three women is likely to be raped during her lifetime.

AN ESTIMATED 32.2% OF RAPE VICTIMS ARE UNDER 20 YEARS OF AGE.[9] Victims under 20 are also less likely to report the crime to the police.[10]

POOR WOMEN ARE MUCH MORE LIKELY TO BE VICTIMS OF RAPE THAN MORE AFFLUENT WOMEN. A 26-city survey conducted by the Department of Justice estimates that women with a family income of less than $10,000 are 11 times more likely to be raped than women with a family income of $25,000 or more.[11]

MANY RAPE VICTIMS FACE UNWANTED PREGNANCIES. An act of unprotected intercourse results in pregnancy about 4% of the time. Rape is not an exception to this rule.

Pregnancy is less likely when the victim is administered a post-coital contraceptive. But the same feelings of fear, shame and isolation which prevent a woman or girl from reporting rape to the police may prevent her from seeking proper medical care. This greatly increases the risk of pregnancy. The claim that psychological trauma somehow prevents pregnancy is unfounded.

NOTES

1. "Profile of Child Sexual Abuse," NCCAN.
2. "Everything You Always Wanted to Know About Child Abuse and Neglect," NCCAN, p.9.
3. David Finkelhor, "Risk Factors in the Sexual Victimization of Children", in *Child Abuse and Neglect*, Vol. 4, p.266.
4. Vincent DeFrancis, *Protecting the Child Victim of Sex Crimes Committed by Adults*, Final Report, (Denver: The American Humane Association, Children's Division, 1969), p.164.
5. T.C.N. Gibbens and J. Prince, *Child Victims of Sex Offenses* (London: The Institute for the Study and Treatment of Delinquency, October 1963), p.16.
6. Uniform Crime Reports, Federal Bureau of Investigation.
7. Menachem Amir, *Patterns in Forcible Rape* (Chicago: University of Chicago Press, 1971).
8. Diana E. H. Russell, Ph.D., *Rape, Child Sexual Abuse, Sexual Harassment in the Workplace: An Analysis of the Prevalence, Causes, and Recommended Solutions*, March 1982, p.16. (Report provided by the National Center for the Prevention and Control of Rape, U.S. Department of Health and Human Services.)
9. M. Joan McDermott, *Rape Victimization in 26 Cities*, (U.S. Department of Justice, Law Enforcement Assistance Administration, National Criminal Justice Information and Statistics Service, 1979).
10. *Rape Victimization in 26 Cities*, p.46.
11. *Rape Victimization in 26 Cities*, p.10.

The Journal, Montgomery County, Md., September 13, 1984 Reprinted with permission by **RCAR** Educational Fund, Inc.

"There wasn't any hope at all."— The story of a sexually abused teen

By M.J. Burke

"Oh, I hated him so much, I was just afraid and ashamed to tell my mother."

Fear and shame. For more than a dozen years they formed the fabric of two young girls' lives as they were repeatedly raped and sexually abused by their stepfather.

Mary, who agreed to talk to The Journal on the condition that her real name not be used, finally summoned the courage this June to tell the Alexandria police about her stepfather's "physical, mental and verbal" abuse of their Del Ray, Va., family.

Her stepfather, a 54-year-old printer who married her mother in 1972, pleaded guilty on Aug. 30 to two counts of raping Mary and her sister. The offenses he was convicted for took place in 1972 and 1974.

For their 12 years of horror, he has been sentenced to 12 months in jail. With good behavior in jail, Mary's stepfather could be out on parole in eight months. He will be on probation for five years.

Timid and just over 5 feet tall, Mary, 27, spoke quietly through intermittent tears about her ordeal. A nervous, hedging laugh punctuated her narrative.

"It went on until recently. He (the stepfather) just had me so well trained that I didn't put up a fight." Smoking nervously, Mary told how her sister, even younger than herself, was forced to share Mary's nightmare.

"Eventually, he started in on my sister. He started caressing her as soon as she came of age. She was 12 when he started on her." She is now 24.

"A couple of times, he had us in bed together, and he would go from one to the other. There was nothing I could do. She was in the same mess that I was in . . . But whenever we'd say no or tell him it was wrong or we didn't want to do it, he would hit us. He would beat us."

When she was young, Mary said she strove to be as unappealing as possible. As other 14-year-olds primped, "I made myself as plain as possible and started gaining weight."

"I started not wearing makeup. I stopped wearing clothes that revealed too much.

"That didn't stop him either."

Her stepfather preyed on the girls when their mother wasn't around. He threatened them with beatings if they revealed their secret.

"My mother worked from 6 in the morning until 2 in the afternoon. During the school year, it would happen on the weekends. In the summer, it would be a lot more frequent."

Finally, the inevitable happened.

"When I first found out I was pregnant (at age 16), I told him I didn't want to have his baby, and he beat me. He said, 'You're going to have this baby.' So I had the baby." Mary's daughter is now 10.

"My sister had two abortions. She almost had a third, but it turned out to be a false alarm.

"At first, my mother didn't know it was going on. When I got pregnant in 1974, I had never been on a date. I didn't know any guys. It had to be him . . . I've never been on a date in my life. We were never allowed to have any friends . . . We had to be home from work by a certain time. We had to be in bed by a certain time."

In a small house, however, the girls' suffering could not continue forever—especially after Mary got pregnant—without their mother's learning about what had taken place. Her husband, a heavy drinker who is now undergoing alcoholism counseling, cowed his wife as well.

"(He) was also abusive to her. She confronted him with it (the pregnancy), and he admitted it to her. She asked why he would want to have sex with a young girl. She asked if he would have sex with his own daughters. He told her that if he had to, he would.

"Then he told her if she tried to do anything about it, he would kill her . . . You would not believe some of the things he would think of to say to her. Her health is not the best. She has emphysema, she's timid—like me—and she's also scared to death of him. He had her trained like he had us trained."

Since her stepfather's arrest, Mary has attended regular family counseling sessions with her mother and sister, with whom she and her daughter still live.

"But we still haven't gotten to the point where we can discuss it yet," she said. "That's a family failing, I think. We never talk about anything. We always keep things secret, in the closet.

"He forced my (older) brothers out of the house when they were 15 and 16, and they were really living on the streets. I was afraid that would happen to me. I had a home, as such, I had a bed to sleep in. I could eat. I survived, and my brothers survived, but I don't know which was worse."

As for Mary herself, "I would take these last couple months of harassment (in her stepfather's prosecution) over the last 14 years any day of the week. It's not perfect, but it's a hell of a lot better."

Under a plea agreement struck between her stepfather's defense attorney and city prosecutors, Judge Donald Haddock sentenced him to 12 months in the city jail and five years' probation. Under Virginia law, he could have been sentenced to up to 40 years in prison for the convictions.

He must also complete a rehabilitation program for his "chronic, late-stage alcoholism", as a medical witness at his hearing defined it. When released from jail, he must stay away from his family or face a five-year prison term.

Her stepfather's sentence, Mary's vindication, leaves her feeling dissatisfied.

"We didn't want him sent to jail for (only) eight months. We wanted him sent away so he couldn't bother us anymore. I'm positive he's going to come back.

"The articles (on the court hearing) I saw were portraying him as a poor, sick broken old man. Like he was a victim . . . He belongs in prison, in an asylum, or dead."

To others caught in a similar trap, especially children, Mary offered this advice:

"I would say that no matter how scared you are of the person, you need to tell a counselor at school, or go to the police. If your mother is as afraid of the person as you are, she won't be able to help you, but there's somebody out there who can.

"Go to anybody. I wish I had done it a lot sooner. It seemed sometimes there wasn't any hope at all."

Religious Coalition for Abortion Rights in Kansas
1248 Buchanan Topeka Ks. 66604 913-354-4823

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

Mr. Chairman and Members of the Committee,

I am Darlene Stearns, State Co-ordinator of Religious Coalition for Abortion Rights in Kansas, a coalition of religious organizations, Protestant, Jewish and others. We hold in high respect the value of potential human life; we do not take the question of abortion lightly.

Because each denomination and faith group represented among us approaches the issue of abortion from the unique perspective of its own theology, members hold widely varying viewpoints as to when abortion is morally justified. It is exactly this plurality of beliefs which leads us to the conviction that the abortion decision must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from government interference.

RCAR members are concerned about the number of teenage pregnancies and the rise in the number of abortions. We believe it is important for the religious community to provide leadership and guidance on the mpral and ethical aspects of this sensitive issue. We support funding for counselling services and support systems for women facing problem pregnancies. We promote establishment of educational programs designed to foster the development of responsible human sexuality. In the material I have given you is a description of an innovative program established in a Chicago high school. This program will do what SB 577 will not do, prevent adolescent pregnancies and prevent abortions.

Firm opposition from the religious community to bills such as SB577 are reflected in a statement by the Presbyterian Church, U.S.A. General Assembly 1983, "Oppose adoption of all measures which would serve to restrict full and equal access to contraception and abortion services to all women, regardless of race, age, and economic standing."

SB 577 does not harm the young middle-class woman coming from a stable, loving family but does harm the young, poor woman already faced with the barriers to health and growth of poverty, ignorance, and fear. She does not need the state to place yet another obstacle in her path by requiring consent from a family that is not there or a judge whom she cannot reach.

In Roe vs. Wade the Supreme Court did not establish an age requirement for a woman seeking a legal abortion. If a woman is old enough to become pregnant, and old enough to become a mother, is she not old enough to decide if she should become a mother?

Darlene Greer Stearns

Darlene Greer Stearns

EDITORIALS

Birth Control Clinic Controversy

SIMPLISTIC MORAL ANSWERS to complex social problems always remind me of a line from the film *Mickey One*. Chased by mobsters, Mickey finally stops a Chicago police car to beg for help. He tells the two officers that his life is in danger because he can't pay his gambling debt. The police look at one another and then reassure the frightened man: "Gambling is illegal in this state; you don't have to pay." Then they drive away.

Teen-age pregnancy is a serious social problem to which the admonition, "Don't do it," is only a first line of defense. As the illegitimate birthrate will attest, that admonition doesn't always help. It hasn't solved the problem at Chicago's DuSable High School, an all-black public institution next to the Robert Taylor Homes—one of those public housing projects that created new sets of problems when they were built, cramming 28,000 residents into a few high-rise apartment buildings.

Earlier this year the Chicago School Board decided that a childbirth rate of more than 30 per cent among the 1,000 girls at DuSable demanded strong measures. So with funding from the state department of public aid and private foundations, the board established a free clinic in the school, staffed by personnel from a nearby hospital.

Children must receive written permission from their parents before visiting the clinic, and an estimated 75 per cent of the students who use the clinic go for health problems unrelated to pregnancy. But in the remaining cases birth control devices are dispensed. Clinic staff interview each student who seeks birth control devices, and the alternative of "saying No" is offered. Prescriptions for pills and the distribution of pills and condoms are not actions that clinic personnel take lightly. As one person related to the program told me, "No one is very happy about dispensing birth control devices to teen-agers." But, as one student's mother observed, "I would rather my daughter come home with pills than with a baby."

The clinic operated without incident through the summer semester. Students were receiving health care in a building that they visited daily. At least five cases of previously undiagnosed diabetes were discovered.

But when the school term opened in September, someone contacted the *Chicago Sun-Times* to urge a closer look at the clinic. Earlier news reports had routinely mentioned the clinic's opening and its dispensing of birth control devices. The *Sun-Times* reopened the issue when it greeted readers with a front-page headline: "Pill Goes to School." For the next few days DuSable's clinic was big news—big enough to get air time on ABC's *Nightline*.

The school board hurriedly put together a public hearing. To no one's surprise, opposition to the clinic came almost exclusively from outside the area, while parents and students from DuSable defended the program. One emotional testimony came from a young woman who turned toward members of a Right to Life organization and, with voice trembling, asked: "Where were you when I was a student here and got pregnant and had to drop out of school?"

The clinic was permitted to continue operation, and plans are under way to open another school-based program in another predominantly black area of Chicago. When that clinic opens, it will be one of more than 30 school-based units in the nation. St. Paul, Minnesota, for example, has operated clinics on school property for 14 years. Statistics there indicate that the number of second births to the same teen-age mother has dropped dramatically—down to 1 per cent.

THESE EFFORTS, however, have barely begun to address this national disgrace: a subculture of women who are trapped in a cycle of early sexual activity, pregnancy, school dropout and single-parent responsibility. Of the more than 700,000 illegitimate births to teen-agers last year, 80 per cent were to girls whose mothers had also been unmarried teen-agers.

Out-of-wedlock births to teen-agers are not confined to the nation's urban black communities, but the problem is certainly centered there. Religious leaders in those

EDITORIAL COMMENT

communities are aware that these are young women trapped in a social vise: Seeking self-esteem or acting out a pattern they see all around them, these girls become mothers when they are just entering puberty. Schooling becomes more difficult, and most of them drop out, severely limiting their economic futures.

An ideal solution to this problem would be to convince these youngsters that they have a moral right to say No to peer pressure. They could also be shown that sexual activity outside of marriage involves exploitation and may lead to the burden of raising children when they have no preparation or money to do so. But such cautionary efforts are not working in the nation's ghettos. Hence school officials in Chicago and other cities have chosen the less desirable but more realistic strategy by providing birth control pills and condoms on school property. Nearby clinics are also helpful, but the greater the accessibility the more likely the students are to secure protective devices.

This logic must have escaped the vehement protesters who visited DuSable in September, bearing placards with

slogans like "Abortion Kills Babies" and "Stop Fornicating." The protesters appear to have come largely from the more zealous wing of the antiabortion movement. One wonders what motivated them to bring their antiabortion zeal to DuSable; birth control, not abortion, is the issue at the school. In fact, birth control devices are being distributed there in an effort to prevent unwanted pregnancies and thereby forestall future abortions.

STILL, THE PROTESTERS objected, which leads to the speculation: Are some segments of the antiabortion forces more concerned with unrestricted sexual freedom than they are with the welfare of a specific fetus? Is it possible that some of the energy behind the movement is generated by antifemale prejudice, envisioning abortion as a means of escaping punishment for sexual behavior? In effect, the strong stance against abortion and distribution of birth control devices could be one way of saying, "You got pregnant because of your sexual activity; now you must carry your child to term as a punishment for your misbehavior."

Perhaps this incident on Chicago's south side can shed some needed light onto the ongoing debate that has been polarized between the extremes of prochoice and antiabortion supporters. The truth must lie somewhere between those extremes. The hint of punishment for sexual freedom which I, for one, detect in the opposition at DuSable suggests a hidden agenda. It is just as wrong to demand that anyone "caught" getting pregnant must carry a fetus to term as a punishment as it is to use abortion as a casual birth control device.

James M. Wall.

No Comment Department

PROMETHEUS BOOKS, a publishing firm in Buffalo, New York, has decided to bring out a book even though its author, Timothy Cooney, has admitted forging an endorsement letter bearing the name of Robert Nozick, chairman of Harvard University's philosophy department. The book, which Random House turned down last fall after discovering the forgery, is titled *Telling Right from Wrong*.

• • •

The following news item appeared in the September 25 issue of the Columbia, South Carolina, *State*: "The Christian Hall of Fame in Greenville will open its Hall of Honor at 6 p.m. Saturday in New Life Christian Fellowship, 212 Roper Mountain Road. The service will mark the induction of Jesus of Nazareth and his twelve disciples."

Renewed Violence in the Inner City

THE YEAR 1981 WAS ONE of startling violence in Britain's inner cities, chiefly in south London's Brixton, in the St. Paul's area of Bristol and in Liverpool's Toxteth. That this violence registered in the States came home to me because at the time I headed the British churches' relief and development agency, Christian Aid, whose headquarters was in Brixton. A cable of sympathy came from Church World Service in New York; American church leaders remembered hot summers of revolt in the inner city. Britain's complacent and even somnolent society knew little of such violence, save in the special situation of Ulster. The notion of the British police losing control of an area even for a few hours would have been considered outlandish until the outbreaks at Brixton and Toxteth.

Britain's concern was so great that one of our most eminent jurists, Lord Scarman (the equivalent, I suppose, of a member of the U.S. Supreme Court), was appointed to lead an inquiry into the 1981 incidents and to suggest courses of action. His report stressed building up a new and strong relationship between the police and the community. As a result, most areas—and certainly those with a racial mix—have been establishing community police committees. (One of my own parish's young elders serves on a committee for Kensington and Chelsea, which, though it contains some of the most expensive housing in the kingdom, also contains Notting Hill where the first race riots happened in the late '60s—about which most people have conveniently forgotten.)

The police were guided toward a new concept of community policing that rests on a good relationship between the police and the community's law-abiding section rather than relying on hard crackdowns to maintain order. Police were encouraged to help run youth clubs and to play football with black youths. Racist attitudes among the police were to be eliminated. (The snag to this goal was that since police officers are products of general society, one would have to eliminate society's racism before the police would be free of it.) Police were to be less the "fuzz" rolling by in vehicles and more the old-fashioned "bobby on the beat." ("Bobby" is an affectionate name derived from Robert Peel, the Victorian statesman who is credited with conceiving the modern police force.)

In the racially mixed and economically deprived Handsworth area of inner Birmingham, community policing was working so well that it had become virtually a showpiece for the Scarman formula. A great carnival was held on September 7 and 8 of this year, which the chief constable of the West Midlands force and many of his officers joined in the chiefly Caribbean merriment.

And then, on the very next day, a policeman gave a parking ticket to a black driver, and suddenly a vast riot flared. Petrol bombs were thrown at police and at fire-

LEAGUE OF WOMEN VOTERS OF KANSAS

Statement to the Senate Committee on Federal and State Affairs
In Opposition to Senate Bill 577
February 25, 1986

In January of 1983, after study and discussion in meetings across the United States, the League of Women Voters announced the following position: "The League of Women Voters believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices."

One of the questions we discussed in the course of this study was whether the state can or should require parental consent before a minor may obtain an abortion. Our members concluded that a minor's access to abortion should not be restricted in this way. Therefore the League of Women Voters of Kansas urges you to oppose passage of Senate Bill 577.

One of the stated goals of this bill is fostering the family structure and preserving it as a viable social unit. That is an objective the League of Women Voters of Kansas can support wholeheartedly, but we do not believe that this piece of legislation will help to achieve that end. Restricting minors' access to abortions may serve to increase the numbers of unmarried, teenage mothers and of babies with no real family to belong to, a trend in our society which undermines the family structure and weakens it as a social unit.

It may be that "parental consultation is usually desirable," as the bill states, but that is certainly not always the case. Parents are not all wise and understanding, or even reasonable; some are neglectful or abusive. Parents and youngsters who cannot communicate with each other over such issues as home-work and use of the telephone are not going to be taught by an act of the legislature to communicate about an emotional issue like teenage pregnancy.

The petition process whereby a minor may obtain court approval for an abortion without parental consent causes delays that add to the cost of the procedure and may affect its safety as well. While the petitions to obtain abortions have almost always been approved, lawsuits challenging these requirements on the basis of the delays have been filed in minnesota and Massachusetts.

The League is also very concerned about the criminal penalties attached to this bill. Raising the classification to aggravated criminal abortion and threatening physicians with a

Attachment # 11

class B felony for performing what is in most cases a legal medical procedure would have the effect of curtailing women's rights to a safe and legal abortion.

We believe that the restrictions that would be imposed by Senate Bill 577 constitute an unnecessary and unwarranted intrusion by the state into matters of private choice and medical decision-making. The League of Women Voters of Kansas asks that you vote no on S.B. 577.

Submitted by Linda R. Johnson, President
League of Women Voters of Kansas

Kansas NARAL

February 26, 1986

TO: SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

FROM: THERESA SHIVELY, EXECUTIVE DIRECTOR

RE: OPPOSITION OF SB 577

KANSAS NARAL, AN AFFILIATE OF THE NATIONAL ABORTION RIGHTS ACTION LEAGUE, BELIEVES THAT ALL WOMEN, NO MATTER WHAT THEIR AGE, SHOULD HAVE ACCESS TO SAFE AND LEGAL ABORTIONS. WE THEREFORE OPPOSE SB 577 WHICH ATTEMPTS TO PROHIBIT OR OBSTRUCT YOUNG WOMEN FROM TERMINATING THEIR PREGNANCIES.

AMONG WOMEN UNDER THE AGE OF 20, THERE ARE A REPORTED 1.1 MILLION PREGNANCIES EACH YEAR. IN SOME OF THOSE CASES, THE MINOR WILL DECIDE TO HAVE AN ABORTION. KANSAS NARAL SUPPORTS ENCOURAGING THE PREGNANT MINOR TO DISCUSS HER DECISION WITH HER PARENTS, SCHOOL COUNSELORS OR RELIGIOUS LEADERS. AND, IN FACT, A MAJORITY OF MINORS WILL DISCUSS THIS MATTER WITH THEIR PARENTS. UNFORTUNATELY, HOWEVER, THERE WILL BE TIMES WHEN THE MINOR FEELS THAT SHE CANNOT CONFIDE IN HER PARENTS.

EFFORTS IN OTHER STATE LEGISLATURES REQUIRING A MINOR TO OBTAIN THE CONSENT OF HER PARENTS BEFORE GETTING AN ABORTION HAVE BEEN PASSED UNDER THE GUISE OF "ENHANCING FAMILY COMMUNICATIONS". IN FACT, THESE LAWS HAVE ONLY SUCCEEDED IN CREATING OBSTACLES AND IN MAKING THE ABORTION DECISION MORE PAINFUL - BOTH EMOTIONALLY AND PHYSICALLY.

FORCING A MINOR AGAINST HER WILL TO INVOLVE HER PARENTS IN THE ABORTION DECISION IS ILL-ADVISED. THE GOVERNMENT CAN NEVER HOPE TO CREATE A PARENT-DAUGHTER RELATIONSHIP BY THE MERE WAVE OF A LEGISLATIVE WAND. INSTEAD OF ENHANCING FAMILY RELATIONS, SUCH GOVERNMENTAL INTRUSION OFTEN EXACERBATES WHAT MIGHT BE AN ALREADY TENSE FAMILY SITUATION. IN CASES WHERE THERE IS AN IRRECONCILABLE DIFFERENCE OF OPINION BETWEEN THE MINOR AND HER PARENTS, THESE LAWS CAN ACTUALLY CONTRIBUTE TO THE BREAK-UP OF THE FAMILY.

THERE CAN BE MANY UNFORTUNATE RESULTS IF THE STATE MANDATES INFORMED CONSENT OF THE PARENTS. THE MINOR MIGHT DENY THE PREGNANCY ALTOGHTER HOPING THAT IT WILL SIMPLY "GO AWAY". SHE MIGHT DELAY THE DECISION, AND MAKE A CLANDISTINE TRIP TO ANOTHER STATE WHICH DOES NOT REQUIRE CONSENT, OR RUN AWAY FROM HOME.

THE U.S. SUPREME COURT HAS ACKNOWLEDGED THAT THERE ARE TIMES WHEN A MINOR CANNOT CONFIDE IN HER PARENTS, AND HAS REQUIRED THAT THE STATE GIVE THE MINOR THE OPTION OF APPEARING BEFORE A JUDGE TO RECEIVE THE NEDESSARY CONSENT. RATHER THAN GUARANTEE "PARENTS' RIGHTS", THIS LEGISLATION CREATES A "SUBSTITUTE PARENT"-THE JUDGE. PARENTS CANNOT BLOCK A MINOR FROM HAVING AN ABORTION UNLESS THE JUDGE DETERMINES THAT THE MINOR IS NOT MATURE AND AN ABORTION IS NOT IN HER BEST INTEREST. NO LEGISLATION CAN LEGALLY GUARANTEE A PARENT'S RIGHT TO PRESIDE OVER HIS/HER MINOR'S PERSONAL ABORTION DECISION.

Affiliate
National
Abortion Rights
Action League

Kansas NARAL

1195 SW Buchanan
Room 201
Topeka, KS 66604
913-235-3405

Sen. Fed. & State Affairs
2/26/86 Attachment 12

Attachment # 12

KANSAS NARAL FEELS THAT THE SO-CALLED "JUDICIAL BY-PASS" IS NOT AN ACCEPTABLE OR WORKABLE ALTERNATIVE:

1. APPEARING BEFORE A COURT IS BOTH INTIMIDATING AND BURDENSOME. THE INTIMIDATION FACTOR CAN FORCE THE MINOR TO PUT OFF HER DECISION INTO THE SECOND TRIMESTER OF PREGNANCY.

2. GETTING AN EXPEDIENT HEARING WITH A JUDGE CAN BE DIFFICULT OR IMPOSSIBLE, GIVEN THE HEAVY CASELOADS OF THE COURTS. A FURTHER OBSTACLE IS THAT SOME JUDGES ACTUALLY REFUSE TO HEAR THESE CASES, FORCING THE MINOR TO TRAVEL SEVERAL HUNDRED MILES AT GREAT EXPENSE.

3. INSENSITIVE COURT PERSONNEL AND INADEQUATE SAFEGUARDS FOR CONFIDENTIALITY GENERATE FEAR AND MAKE THE COURT EXPERIENCE A TRAUMATIC ONE.

4. ALTHOUGH THE JUDGE DECIDES WHETHER THE MINOR IS MATURE ENOUGH TO HAVE AN ABORTION, NOWHERE IS ADDRESSED THE QUESTION OF HER MATURITY TO BECOME A MOTHER.

VIRTUALLY ALL ABORTION PETITIONS WHICH HAVE COME BEFORE THE COURTS HAVE BEEN GRANTED. WHILE LAWS MAKE IT HARDER FOR A MINOR TO OBTAIN AN ABORTION AND SERIOUSLY THREATEN HER EMOTIONAL AND PHYSICAL WELL BEING, FORCING A MINOR BEFORE A JUDGE OR HER PARENTS NEITHER FOSTERS COMMUNICATION WITHIN THE FAMILY NOT SERVES ANY CONSTRUCTIVE PURPOSE.

WE ASK YOU TO OPPOSE SB 577 FOR THESE REASONS.

THANK YOU FOR ALLOWING ME TO APPEAR HERE TODAY, I WILL BE HAPPY TO STAND FOR QUESTIONS.

May 15, 1985

President Ronald Reagan
c/o CARAL
Box 14022
Cleveland, Ohio 44101

Dear President Reagan:

I am a 17 year old, and I will graduate this June. I'm a good student and have been on the honor role most of my junior and senior year. I have a part-time job and I want to go to college, if I can get the tuition together.

My boyfriend is 18 and he is graduating too. He has been working since he was 14, and he gives his mom $10 a week.

My parents are divorced. My Mom gets ADC and I'm the oldest. She's really proud of me, and she'd be awfully disappointed if she knew I was pregnant. I just couldn't do that to her. She's always tried to make us kids try to better ourselves. She never had a chance, so she wanted us to have one. She used to take us to the library when we were little, even though she could hardly read herself. But she learned. But she just kept having babies, she never had a chance to do anything else.

I was really dumb to get pregnant. I just didn't have the money to get the prescription refilled, so we took a chance, without using anything.

Well, I'm getting this abortion. My boyfriend is with me. We managed to borrow some of the money from his brother, and the clinic is letting us pay the rest of it in installments. If they hadn't done that, I don't know what I'd have done.

I went to one of the places that is supposed to help you if you're pregnant. They offered me a baby bed, some bottles, and a few diapers, and said I didn't have to keep the baby, they'd help me get the baby adopted. I told them I don't plan to give up a baby if I can have it, I'll keep it. But I'm not raising any baby on welfare, and that's the kind of help they were offering me. They were going to help me get on welfare of my own. No, when I get married and have a family, it isn't going to be on welfare.

I didn't want to have an abortion, but it's better than being pregnant when you're just a kid.

Dawn

44106

KANSAS

TO: MEMBERS OF THE SENATE COMMITTEE ON FEDERAL AND STATE AFFAIRS

FROM: ANNE MORIARTY - KANSAS NATIONAL ORGANIZATION FOR WOMEN

DATE: FEBRUARY 26,1986

RE: SB 577

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I REPRESENT THE KANSAS NATIONAL ORGANIZATION FOR WOMEN. N.O.W. OPPOSES SB 577 AND IS IN AGREEMENT WITH THE COMMENTS ARTICULATED BY THOSE CONFEREES WHO PRECEDED ME THIS MORNING. RATHER THAN REITERATE ALL THOSE REASONS WHY N.O.W. FEELS THIS IS A BAD BILL, I WOULD LIKE TO APPROACH THE ISSUE FROM A DIFFERENT ANGLE.

ONE OF THE PROPONENTS OF THIS BILL STATED YESTERDAY THAT ABORTION IS NOT THE PROBLEM, NOR THE ANSWER; THAT SEX AMONG TEENAGERS IS THE PROBLEM. N.O.W. BELIEVES THAT INDIVIDUAL WAS ON THE RIGHT TRACK. HOWEVER, WE WOULD RE-PHRASE THE FOREGOING SENTENCE TO SAY: "ABORTION IS NOT THE PROBLEM, ABORTION IS ONE ANSWER TO THE PROBLEM, THE PROBLEM IS TEENAGE PREGNANCY.

THE SPIRALING PROBLEM OF TEENAGE PREGNANCY HAS NOW REACHED CRISIS PROPORTIONS. EACH YEAR 1,000,000 TEENAGERS IN THIS COUNTRY BECOME PREGNANT. FOUR OUT OF FIVE ARE UNMARRIED. ACCORDING TO A TIME MAGAZINE COVER STORY IN THE DECEMBER, '85 ISSUE ENTITLED "CHILDREN HAVING CHILDREN," RESEARCHERS ESTIMATE THAT 40% OF TODAYS 14-YEAR OLDS WILL BE PREGNANT AT LEAST ONCE BEFORE THE AGE OF 20 IF PRESENT

TRENDS CONTINUE. THE U.S. IN FACT, HAS THE HIGHEST RATE OF TEENAGE PREGNANCY, BIRTH, AND ABORTION IN THE WESTERN WORLD.

TEEN PREGNANCY IMPOSES LIFELONG HARDSHIPS ON BOTH PARENT AND CHILD. TO QUOTE SENATOR MOYNIHAN OF NEW YORK, "WHEN AN UNWED TEENAGER GIVES BIRTH, A BROKEN FAMILY IS FORMED." TEENAGE PREGNANCY AND PARENTHOOD ARE ASSOCIATED WITH A MULTITUDE OF SOCIO-ECONOMIC AND MEDICAL PROBLEMS. MEDICALLY SPEAKING, TEENAGE MOTHERS ARE MORE LIKELY TO DIE OR SUFFER PREGNANCY-RELATED HEALTH COMPLICATIONS THAN MOTHERS IN THEIR EARLY 20'S. BABIES OF TEENAGERS ARE AT A 39% GREATER RISK OF HAVING A LOW-BIRTH WEIGHT; A MAJOR CAUSE OF INFANT MORTALITY, VARIOUS ILLNESSES AND DEFECTS. THESE CHILDREN ARE ALSO MORE LIKELY TO SUFFER ABUSE AND NEGLECT FROM THEIR IMMATURE PARENTS.

BECAUSE TEENAGE PREGNANCY AND PARENTHOOD ARE LINKED TO SO MANY SOCIETAL PROBLEMS, IT IS ESSENTIAL THAT STATE LEGISLATURES BEGIN TO LOOK AT WAYS TO PREVENT TEENAGE PREGNANCIES.

LADIES AND GENTLEMEN, SB 577 IS NOT THE ANSWER. IF YOU WANT TO LIMIT THE NUMBER OF ABORTIONS PERFORMED ON TEENAGERS, THEN YOU MUST ATTACK THE PROBLEM AT THE ROOT--TEENAGE PREGNANCY. YOU MUST NOT RESTRICT ABORTION, WHICH WILL ONLY EXACERBATE THE PROBLEM OF CHILDREN HAVING CHILDREN.

LEGISLATORS MUST GET BEYOND THE IDEA THAT YOU CAN PREVENT TEENAGERS FROM HAVING SEX, AND YOU MUST USE THE POWER AND AUITHORITY OF YOUR OFFICE TO ELIMINATE THE TRAGIC CONSEQUENCES OF TEENAGE PREGNANCY. TO QUOTE AN EDITORIAL IN THE CHICAGO TRIBUNE AND REPRINTED IN THE K.C. STAR (11/20/85) "PERHAPS THIS WOULD BE A BETTER WORLD IF NO ONE ENGAGED IN SEX EXCEPT HUSBANDS AND WIVES AND ONLY WITH EACH OTHER. NO DOUBT IT WOULD BE A BETTER WORLD IF TEENAGERS AVOIDED PREGNANCY BY REFRAINING FROM SEX OUT OF PRUDENCE AND MORAL-

ITY...BUT THIS WORLD HAS NEVER BEEN THAT WAY. IF ANYTHING, IT IS LESS THAT WAY THAN IT USED TO BE." YOU CANNOT LEGISLATE CHASTITY AND MORALITY, AND YOU CANNOT ELIMINATE SEXUAL ACTIVITY AMONG TEENAGERS BY RESTRICTING THEIR ACCESS TO ABORTION. TO QUOTE MARY MUSHINSKY, STATE LEGISLATOR FROM CONNECTICUT: "SOME OF YOUR CONSTITUENTS WILL SAY, 'THESE KIDS SHOULD NOT BE HAVING SEX,'RATHER THAN 'HOW CAN WE PREVENT TEENAGE PREGNANCY?' THAT'S LIKE WATCHING A HOUSE BURN DOWN AND SAYING, 'GEE, THE PEOPLE IN THAT HOUSE REALLY OUGHT TO PUT IN SMOKE DETECTORS. WELL, SURE, THEY SHOULD HAVE, BUT IT'S TOO LATE NOW. WHAT YOU HAVE TO DO AS LEGISLATORS IS FOCUS ON REDUCING THE TEENAGE PREGNANCY RATE--YOU CAN'T GET THE KIDS TO STOP HAVING SEX."

WHAT IS NEEDED IS AN INNOVATIVE APPROACH, AND THE FEB.'86 ISSUE OF STATE LEGISLATURES IN ITS COVER STORY ON TEENAGE PREGNANCY DISCUSSES JUST SUCH AS APPROACH. THE WISCONSIN LEGISLATURE PASSED A LANDMARK BILL LAST NOVEMBER, WHICH SEEKS TO REDUCE THE NUMBER OF TEENAGE PREGNANCIES AND ABORTIONS. THE WISCONSIN ABORTION PREVENTION AND FAMILY RESPONSIBILITY ACT OF 1985 STRIKES A BALANCE BETWEEN THE RIGHT TO LIFE AND THE RIGHT TO PRIVACY. KEY ASPECTS OF THE LAW ARE:

* MAKING PARENTS RESPONSIBLE FOR THE SUPPORT OF THEIR MINOR CHILDREN'S BABIES UNTIL THE TEEN PARENT BECOMES AN ADULT.

* HOSPITALS MUST STRONGLY ENCOURAGE MINORS TO CONSULT THEIR PARENTS BEFORE HAVING AN ABORTION, HOWEVER, THE LAW PROHIBITS NOTIFICATION OF A PARENT ABOUT AN ABORTION WITHOUT THE MINOR'S WRITTEN CONSENT.

* THE LAW ALLOCATED $1,000,000 FOR ADOLESCENT PREGNANCY PREVENTION PROGRAMS AND PREGNANCY SERVICES.

* REQUIRES SCHOOL BOARDS TO SET UP HUMAN GROWTH AND DEVELOPMENT CURRICULA.

* REPEALS COMMERCIAL RESTRICTIONS ON NON-PRESCRIPTION CONTRA-

CEPTIVES.

* EXPANDS THE CURRENT SCHOOL-AGE MOTHERS PROGRAM TO INCLUDE SCHOOL-AGE FATHERS.

* REQUIRES THE PROGRAM TO INCLUDE PARENTING SKILLS, FAMILY PLANNING AND INFORMATION ON ADOPTION SERVICES.

* CREATES A STATE ADOPTION CENTER FOR INFORMATION AND REFERRALS.

THIS LAW WAS THE RESULT OF A TASK FORCE, WHICH BROUGHT TOGETHER ABORTION FOES AND PRO-CHOICE ADVOCATES TO STUDY THE PROBLEM OF TEENAGE PREGNANCY. A MEMBER OF THE WISCONSIN LEGISLATURE WHO WAS A MEMBER OF THE TASK FORCE AND A STRONG ABORTION FOE SAID, "WE CAME TO REALIZE THAT PRO-CHOICE AND PRO-LIFE ADVOCATES CAN FIND COMMON GROUND. THE RESULT OF OUR WORK IS A NON-PARTISAM PIECE OF LEGISLATION THAT IS DEFENDABLE IN TERMS OF BOTH THE PRO-CHOICE AND THE PRO-LIFE VIEWPOINT."

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I URGE YOU TO SCRAP SB 577 AND INSTEAD TAKE THE BOLD STEP OF FOLLOWING WISCONSIN'S LEAD IN ATTACKING THE REAL PROBLEM, TEENAGE PREGNANCY, IN A WAY, WHICH COULD BE PALATABLE TO BOTH THE PROPONENTS AND OPPONENTS OF THE CURRENT BILL IN QUESTION.

THANK YOU FOR THE OPPORTUNITY TO APPEAR. I'D BE HAPPY TO ANSWER ANY QUESTIONS.

Editorial review

KC Times 11/20/85

Getting smarter about teen-age sex

From The New York Times:

A family is formed when a child is born," Senator Moynihan of New York said in a lecture last spring. "When an unwed teen-ager gives birth, a broken family is formed."

More than 270,000 of those broken families are formed every year in the United States. New York City alone accounts for 12,000. And those 270,000 young mothers constitute only a quarter of America's pregnant adolescents. There are more than a million of them yearly; half miscarry or choose abortion, a fourth hastily marry.

What do these youngsters have in common, besides youth and pregnancy?

It's not poverty; youthful sexual activity is hardly restricted to the poor. Nor is it race. The pregnancy rate among black teen-agers is high; the white rate exceeds that for adolescents in France, Sweden, England, Canada, Wales and the Netherlands.

What these girls have most importantly in common is America — the undisputed champion of the sexual sell. So what has America done to prepare its children for life in a country where sex is used to hawk everything from jeans to detergents — and whose citizens are told to "have good sex" as routinely as they're advised to floss their teeth? Until recently, next to nothing. Contraceptive counseling and sex education in the schools have suffered constant attack. Some states still limit the advertising and display of contraceptives. Only last month NBC and CBS finally agreed to run a public service message about pregnancy prevention.

But Americans are not as reluctant to acquaint their children with sex as such quasi-censorship suggests. Last winter, a survey sponsored by the American College of Obstetricians and Gynecologists showed overwhelming support for sex education; 54 percent of the female respondents said it should start in elementary school. Last week, a study sponsored by Planned Parenthood reported similar findings.

Yes, said 85 percent of those polled, sex education should be part of the school curriculum; 67 percent favor requiring schools to establish links with family-planning clinics. A majortiy also criticize television for fostering permissiveness, and favor birth control information on TV.

If recognizing a problem is halfway to solving it, then America may finally be on its was to doing something about children who bear children. Without such a commitment to education and communication, the number of broken families formed every year will keep on growing.

Abortion foes ought to favor 'family planning'

KC Star 11/20/85

By Jon Margolis
Chicago Tribune

Washington—First, in the spirit of full disclosure and the new policy of the pop music industry, a warning to parents: What follows concerns one of those subjects we are not supposed to discuss in front of the kids. Not religion, not politics. The other one.

Second, what is about to be stated cannot be proven, not with statistics from the Census Bureau, not with quotes from academics. Oh, there are always psychiatrists to consult, but only in defiance of Samuel Goldwyn's observation that "anyone who goes to a psychiatrist ought to have his head examined."

Third, most people who support the anti-abortion movement are decent and honorable folks who have no motive other than their moral convictions.

OK, now come up to the latest wrinkle in the abortion battle, which is the plan to deny federal money for family planning to all organizations that even talk about abortions, whether or not they actually perform them.

Forget for a moment all the politics and the arcane bureaucratic arguments surrounding the issue. The interesting point here is the link between family planning and abortion.

First, it would be helpful to cut through the euphemisms. "Family planning" is the polite term for "birth control," which in turn is the polite term for having sex without having babies. In the real world, birth control often has nothing to do with family planning, benefiting as it does couples who do not make up a family because they are not married.

By whatever name, birth control ought to be encouraged by anti-abortion activists. It solves the problem. A woman who does not get pregnant does not have to decide whether to have an abortion. Were birth control accessible, easy to get, inexpensive and commonly used, abortions would be so rare that we wouldn't have to argue about them. And wouldn't that be nice?

Actually, birth control is accessible, easy to get and inexpensive. It's just not all that commonly used, especially by teen-agers and the less affluent, less educated women who are the ones less able to care for babies, hence more tempted to have abortions.

As it turns out, though, many of the leaders of the anti-abortion movement also oppose birth control. There are some legitimate philosophical reasons for this position, but there is one not-so-philosophical reason: sex.

It it is hard to spend much time around the right-to-life movement without noticing that lurking beneath the surface of the psyches of some (not all) of its leaders is a profound unease about sex. It is as though many in the movement are subconsciously saying, "There's all this mifky-pifky going on, but not for me, and I'm envious." Or, in a few cases, "For me, too, and I'm feeling guilty."

The same holds for those (many of them the same people) who have led the fight against the Equal Rights Amendment. When they claim that feminism "threatens the family," what they are really saying is that if women go out in the world of work they will be open to all those temptations that start around the water cooler or over coffee in the employee cafeteria and end up who-knows-where.

As conceded, it is impossible to prove this. But it is hard not to notice it.

Perhaps this would be a better world if no one engaged in sex except husbands and wives, and only with each other. No doubt it would be a better world if teen-agers avoided pregnancy by refraining from sex, out of prudence and morality, and there is nothing wrong with telling them so.

But this world has never been that way. If anything, it is less that way than it used to be, and the frustrations (or envy, or guilt) of those who are upset over the world as it is ought to be understood.

By all the available evidence, they are fighting a losing battle. Having staved off the onslaught of night baseball and David Letterman, sex, it seems, is here to stay.