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Early Head Start and Teen Parent Families: Partnerships for Success

About This Brief

This issue brief focuses on the special needs of teenage parents and their children ("teen parent families") and on how the unique set of services available through Early Head Start (EHS) programs can support them. Teen parent families face multiple risks, risks that may be substantially different from those faced by families with older parents and that may be further complicated by issues involving disability, abuse, or neglect. These issues are interrelated and must be integrated and addressed as programs design services to meet the needs of this population. Specifically, the brief examines the benefits of EHS participation for teen parents involved with the child protective services system and for those with disabilities.

Many of the insights shared in this brief are drawn from a working meeting involving EHS providers and experts from a number of fields, held at CLASP in 2005. The two-day session focused on the special issues facing teen parent families engaged in Early Head Start. In addition to general policy issues, participants spent substantial time discussing the distinct barriers faced by teen parents in Early Head Start when either the children or parents had disabilities or the family was involved with the child welfare system.

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Overview of Early Head Start

The federal Head Start program provides comprehensive early education and support services to low-income children and their families. Head Start began in 1965 as a preschool program for four-year-olds. Since that time, Head Start has grown to serve pregnant women and children birth to five. In 1995, policymakers created Early Head Start (EHS) to reach children under age three and pregnant women. The program was created in part as a response to research on brain development and the importance of children's earliest relationships.[1] EHS provides children and their families with access to a range of services tailored to meet the unique needs of very young children and pregnant women. These include parenting resources; nutritious meals and health education; comprehensive medical, dental, and mental health screenings and referrals for follow-up treatment; access to pre- and post-natal care for pregnant women; and social services and referrals for the entire family. While substantially smaller than Head Start, EHS now has more than 740 programs and serves more than 80,000 children around the country,[2] although nationally the program reaches only 2.5 percent of eligible children.[3]

EHS is a federal program within the Office of Head Start that provides grants directly to local programs. Grantees have broad discretion in administering EHS—provided they meet the federal Head Start Program Performance Standards, which require high educational standards and comprehensive social services for children and families. Grantees must conduct a community needs assessment to determine which type of EHS program best meets the needs of families in the community:

- **Center-based programs** provide child care and early education services in a center operated directly by EHS or through a child care partner. In addition, families must receive at least two home visits per year.
- **Home-based programs** administer EHS services through weekly home visits with the caregiver and child. Families also attend group socialization activities at least once a month.
- **Mixed-delivery programs** combine the center-based and home-based approach. In these programs, some families receive EHS services solely via center-based or home-based settings, others via a combination of the two. Some programs also contract with family child care providers, who operate with oversight from center-based staff and home visits.

Another option is a locally-designed program, which must be approved by the federal government.

Generally, children and pregnant women are eligible for EHS if they are from families below the federal poverty level.[4] They may also be eligible if they participate in a public assistance program or are in the foster care system.[5] In addition, up to 10 percent of participants may be over income.

Background: What do We Know About Teen Parents and their Children in EHS?

Families headed by teenage parents face multiple risk factors and may need services tailored to meet their unique needs. In addition, emerging research shows teens are still developing

cognitively, physically, and emotionally and therefore may require approaches to learning how to be better parents that are geared toward their developmental level.[6] Children of teen parents may also be more at risk than children of older mothers. They are more likely to have low birth weight, to perform poorly on cognitive and behavioral tests, to be reported as abused or neglected, and to be placed in foster care. These risk factors may interrupt healthy physical, social, emotional, and cognitive development and lead to problems that place children at risk for academic failure.

National data on the number of EHS participants with teenage parents is not available. However, teens under age 18 comprised 20 percent of pregnant women participating in EHS in 2006.[7] Since teen parent families likely comprise a substantial portion of families receiving services through EHS, insight into these families' needs is valuable to EHS providers and policymakers.

The Early Head Start Impact Study

The U.S. Department of Health and Human Services (HHS) authorized a study of 17 EHS programs, selected to be representative of all EHS programs funded in 1995-1996. The final report, titled *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start* (June 2002), presents findings at age three, after children had participated in EHS for two to three years. The study included a large sample of children with mothers—39 percent—who were teenagers when the Head Start focal child was born. For the purposes of analysis, parents who were teens at the time of their child's birth were included in the "teenage parents" subgroup, regardless of their current age. Among the EHS programs included in the study, the proportion of teen mothers ranged from 19 to 90 percent. Two of the programs in the study specifically targeted teen parent families, and more than 50 percent of the children in these programs were born to teen parents.[8]

Even though EHS is not designed specifically to meet the needs of teenage parents, the program had significant positive impacts on teenage parent families. Although EHS staff report that children with teen parents can be harder to serve, participation in the program was linked to several positive impacts on parenting, child development, and economic self-sufficiency. Although EHS participation is linked to positive outcomes for all participating children and their parents, the impact on child development and parenting was greater for families headed by parents age 20 and older than for teen parent families. The authors of the study suggest that this pattern may be attributable to the fact that teen parents are less likely to be emotionally mature and are less receptive to services. Despite this difficulty, the study indicated that EHS participation benefited teen parent families in several significant areas—child development, access to support services, parenting behavior, and economic self-sufficiency.[9]

Child Development

Participation in EHS had significant positive developmental impacts for all children, according to the *Making a Difference* study. Findings specific to children of teenage parents include:

- Children of teenage parents who participated in EHS were less likely to be identified as developmentally at risk, as measured by the Bayley Scales of Infant Development Mental Development Index, a cognitive development test.[10]

- EHS participation had positive impacts on socio-emotional development and parent-child interaction for all children. EHS participation had a greater impact on sustained attention to objects during play for children of teen parents than for children of parents age 20 and over. EHS also produced favorable, but not statistically significant, impacts on negativity and aggression in all participating children.
- EHS significantly improved the language development of children with mothers age 20 and over but had no statistically significant impact on the language development of children of teenage mothers.[11]

Access to Support Services
Teen parents of EHS participants accessed more support services than teen parents in the control group, suggesting that EHS linked teen parent families with services they might not have otherwise accessed. However, teen parents in EHS accessed fewer services than parents age 20 and over. In addition, EHS program staff report that teen parents are more difficult to serve and less likely to be "highly involved" in the EHS program, as measured by staff reports and length of time spent in the program.[12]

Parenting Behavior
EHS participation had the broadest impact on the parenting behavior of older mothers. In some areas—such as shared book reading and other practices that support early language development—EHS participation had a positive effect on parents over age 20 but not on teen parents. But in other parenting domains, positive effects were seen in older parents and teen parents alike:

- Parents of children participating in EHS were less likely to report using physical punishment as a discipline strategy than were parents whose children did not participate in EHS.
- EHS participation was linked to increased levels of parent supportiveness during parent-child play.[13]

Economic Self-Sufficiency
The *Making a Difference* study also examined the impact of EHS participation on involvement in "self-sufficiency activities" (education, employment, and welfare receipt) for both teenage parents and those age 20 and older. Findings pertaining to teen parent families include:

- EHS participation increased enrollment in school for teenage parents. However, teen parents with children in EHS were no more likely than the control group to obtain a high school degree or GED.

- EHS participation increased

The Locklin Technical Center (rural/suburban Santa Rosa County, Florida) is a model program that combines a teenage parenting program with EHS. The goal of the Teen Age Parenting Program (TAPP) is to offer pregnant and parenting girls the opportunity to return to or continue their education and earn a high school diploma. Simultaneously, students gain practical-parenting, career-planning, and life-management skills. Along with attending academic classes for high school graduation, the TAPP student has the added advantage of attending a technical training program—at no cost—to increase her employment and marketability while earning her diploma. Some of the services offered by Locklin Technical Center include parenting classes, high school diploma or GED programs, onsite vocational classes, free child care in an accredited child care center, subsidized lunches, and a clothes closet for teens and children.

employment rates among older mothers but had no significant impact on the employment of teenage mothers. Lower levels of employment among teenage parents could be due to higher rates of school enrollment.

- EHS participation is linked to an initial increase in welfare receipt among teenage parents, followed by a significant decline in welfare receipt. EHS participation did not have a significant impact on welfare receipt among older mothers.[14]

Teen Parent Families, Child Abuse and Neglect, and Disabilities

Families with teen parents may face additional risk factors, including child abuse and neglect or children or parents with disabilities. The findings around EHS indicate that the program may have promise for teen parent families in addressing these risk factors, especially when programs are supported by and collaborate with external programs and agencies.

Partnering with Child Welfare

Children in foster care are eligible for Head Start and EHS regardless of family income.[15] However, only 3 percent of children served qualify due exclusively to this factor. On the other hand, the number of families both involved with EHS and receiving services for child abuse and neglect is growing rapidly—it increased 16 percent between 2005 and 2006, while the total number of families in EHS increased by just 3 percent.[16] The purposes of EHS, the early intervention system, and the child welfare system are complementary—each seeks to ensure that children grow up in healthy environments and reach their full potential. Therefore, the three should play key and coordinated roles in the lives of children who have experienced abuse or neglect—especially children of teen parents.[17]

Children of teen parents are too often at risk of entering the child welfare system. One significant study found "evidence of a significant relationship between maternal age and the likelihood of substantiated child abuse/neglect and foster care placement."[18] Children of teen parents are particularly at risk for severe abuse, including infant homicide. One study found that the most important risk factors for infant homicide were a second or subsequent infant born to a teen mother, a maternal age of less than 15 years, no prenatal care, or less than 12 years of education (for mothers age17 or older).[19]t An Illinois study found that reported child abuse and neglect were highest among women who became mothers as teenagers.[20] Also, federal data show that infants make up the largest single group of victims of substantiated child maltreatment.[21] They are also the largest age group to enter foster care, accounting for one in five admissions over the past decade.[22] Unfortunately, several key risk factors for child abuse and neglect are clustered in the teen parent subpopulation, including poverty and single parenthood. Many teen parents may also be in the child welfare system themselves, or have a history in it.[23]

Poverty is the strongest predictor of child abuse and neglect. Children who live in families with incomes of less than $15,000 are 22 times more likely to be abused or neglected than children who live in families with incomes of $30,000 or more.[24] Because EHS is targeted at poor families with infants and toddlers, it may be able to provide teen parents with needed interventions and links to services that can help prevent abuse and neglect of this most vulnerable population.

Many teen parents have additional barriers to cross as well. Youth aging out of the foster care system often experience problems with the transition to independence—which often means becoming an adult with little or no family support. For teen parents, the implications of this transition are important not only for the teen but for her child(ren). EHS can provide access to services to ease these transitions and to give additional supports to teen parents and their children at this critical time.

Data suggest additional reasons to build connections between EHS and the foster care system. Infants and toddlers placed in foster care often face significant developmental difficulties. According to data from HHS, the rate of foster care participation for children entering early intervention is seven percent—10 times the rate for the general population.[25] Recognizing that child abuse and neglect are strongly linked to developmental delays or disabilities, Congress in 2003 amended the Child Abuse Prevention and Treatment Act to require state child welfare agencies to refer children under age three with a substantiated case of abuse and/or neglect to the Individuals with Disabilities Education Act's (IDEA) early intervention program (often called "Part C").

Family Services of Grant County (Moses Lake, Washington State) was formed in 1983 to assist teen parents and their children and to encourage teen parents to remain in high school. In 1998, the program expanded to include an EHS program. The goal of the program is family reunification for children in foster care. In recognition of the demographics of the county, the program created PACT (Parents and Children Together), an EHS-child welfare partnership, serving eight children, their biological parents, and their foster parents. The program creates an environment that nurtures the full range of children's development while involving parents, caregivers, foster parents, and social workers in a partnership relationship designed to foster knowledge and parenting skills.

Source: Zero to Three Technical Assistance Paper: *Supporting Infants and Toddlers in the Child Welfare System: The Hope of Early Head Start.* 2005. Zero To Three: Washington D.C. (Technical Assistance Paper No. 9). Available at http://ehsnrc.org/PDFfiles/TA9.pdf

The federal Office of Head Start has taken some steps to address the link between child welfare and EHS participants of all ages and has provided some funding for pilot projects to support collaborations between EHS and child welfare services agencies. Through the Child Welfare Services and Early Head Start (EHS/CWS) initiative, a select group of EHS grantees have partnered with their local child welfare agencies to demonstrate how best to serve children in the child welfare system using the EHS model. This effort was not focused on teen parents alone, but the programs may provide promise toward the linkage between teen parents and EHS. In Fiscal Year 2002, three-year grants were awarded to fund 24 demonstration projects, some of which were created specifically out of links with teen parent programs.

EHS and the Prevention of Child Abuse and Neglect

Studies have found linkages between physical punishment and child abuse. For instance, parent reports suggest that as many as two-thirds of abusive incidents begin as attempts to change children's behavior or "teach them a lesson."[26] Some states specifically include excessive corporal punishment in definitions of abuse.[27] By focusing on parenting behaviors, EHS programs may prevent some participating children from becoming involved in the child welfare system.

As discussed earlier, the HHS *Making A Difference* report found that parents with children in EHS were more likely than those in the control group to exhibit positive parenting behaviors and avoid behaviors that may put children at risk for abuse or neglect. EHS is a good partner for child welfare programs seeking to prevent maltreatment and to safely maintain or reunify children who have experienced abuse with their teen parents.

From the Early Head Start National Resource Center at Zero to Three, at http://www.ehsnrc.org/highlights/childwelfare.htm

Child Welfare Services and Early Head Start Initiative

In Fiscal Year 2002, grants were awarded to fund 24 demonstration projects for a period of three years. The number of children from the child welfare system being served by the EHS/CWS projects varies from 4 to 40 children, with most grantees serving between 8 and 20 children. Across all 24 projects, funding is available to provide Early Head Start services to 397 children from the child welfare system.

The Children's Bureau is the sponsor for the evaluation activities that are part of the project. Each of the EHS/CWS grantees is expected to conduct its own local evaluation and is being provided with evaluation TA, as necessary, through James Bell Associates. The purpose of this TA is to assist with evaluation design, build local capacity to conduct evaluations, and strengthen the evaluations that are implemented. After three years of program implementation, EHS/CWS grantees are required to submit a final report on their local evaluations to the Children's and Office of Head Starts. Findings reported by clusters of grantees will be used for a cross-site evaluation, where a synthesis of findings from projects that addressed common outcomes will be performed.

There is variation in the types of children that EHS/CSW grantees enroll in their programs. The target population in the child welfare system that the EHS/CSW grantees intend to serve may include both infants and toddlers at some projects, while others may target only infants or only toddlers. Some programs are serving children in the child welfare system who remain at home but receive ongoing Child Protective Services, while other projects are targeting children who are removed from the home and placed in foster care or other out-of-home care arrangements. Other programs are serving children who are part of the child welfare system because they are considered at-risk for abuse or neglect. In addition, programs may choose to focus on children whose parent(s) have additional presenting problems, such as those whose parents are incarcerated or those whose parents are in substance abuse recovery programs.

Although all grantees are developing their unique theory of change and a locally-designed evaluation, most EHS/CWS projects are addressing outcome objectives that include safety, permanency, and well-being for children. Many of the grantees also have developed evaluation plans to measure intermediate outcomes that are expected to occur prior to these longer-term outcomes, including improved parenting skills, improved parent-child interactions, and increased coping strategies to deal with stress.

Partnering with Early Intervention and Disability Services

Data suggests that children born to teen mothers may be at greater risk for a variety of developmental issues.[28]

Teen mothers give birth to low birth-weight babies at higher rates than older mothers do—21 percent higher than mothers ages 20 to 24.[29] Low birth weight is often an indication of developmental difficulties; nearly one-third of the children receiving early intervention services were born at low birth weight, compared with 7.5 percent of the general population.[30]

Early identification and treatment of infants and toddlers with disabilities are critical to later success. EHS programs are designed both to help identify children who may have disabilities and to facilitate access to services for these young children and their families.

Part C supports developmental services for infants and toddlers up to age three with developmental disabilities and delays, and it provides services to their families. Part C was established to ensure that these children and their families receive individualized early intervention services, as well as to enhance children's developmental potential, enhance the capacity of families to meet the needs of their infant or toddler with disabilities, and improve and expand existing early intervention services being provided to children and their families.[31] For children with disabilities, early diagnosis and service are likely to have a positive impact on school readiness.

Early Intervention Services

Children who have significant disabilities are generally eligible for Part C services. Certain other functional limitations or diagnosed conditions—including crossed eyes or nearsightedness, epilepsy or seizures, hyperactivity, or a developmental delay—might make the child eligible for early intervention services as well. Part C requires the development and implementation of an Individual Family Service Plan (IFSP) for each eligible child. The plan must take into consideration all the information gathered from the evaluation and child and family assessments in determining the appropriate services needed to meet the needs. Importantly, each eligible family must be provided with a service coordinator, who arranges for assessments and IFSP meetings and facilitates the provision of needed services. The service coordinator coordinates required early intervention services, as well as medical and other services the child and the child's family may need. The service coordinator prevents families from having to locate essential services, negotiate with agencies, and coordinate service needs on their own. See http://www.ed.gov/policy/speced/guid/idea/idea2004.html

The Head Start Program Performance Standards,[32] which apply to EHS, require that 10 percent of program enrollment opportunities be available to children with disabilities—and that grantees coordinate with Part C agencies.[33] Once an EHS child has been found eligible for Part C-funded services, families, EHS, and providers of early intervention services must work together.[34] For example, some early intervention services have been provided, along with other services, in EHS classrooms. Additionally, some early intervention and EHS programs have made joint home visits a regular part of their program, in order to provide parents with more integrated comprehensive support and feedback.

What Do We Know About the Effect of EHS on Teen Parent Families and Disabilities?
The data in three areas—cognitive development among children of teen parents, social-emotional behavior among children of teenage parents, and parenting behavior—indicates that EHS programs are a promising approach to addressing disabilities for children of teen parents. Coordination among Part C programs, Early Head Start, and teen parent programs is critical. More than 11 percent of children receiving intervention services through Part C were born to mothers under the age 18.[35] However, one EHS report—*Research to Practice: Children with Disabilities in Early Head Start*, the findings of which were drawn from the *Early Head Start Research and Evaluation Project*—found that children of teen parents were less likely than children with older parents to receive Part C services.[36] The study also reported that, despite nearly all of the children receiving well-baby examinations, many parents appeared to be unaware of their children's cognitive delays. Of the teen parents of children who scored below 70 on the Bayley Mental Development (MDI) cognitive test, making them eligible for Part C services, very few reported that a doctor had told them that their child had a developmental delay.[37]

Providers at the EHS working session held by CLASP reported that teen parents often lack information about their child's disability. Adolescent mothers are often less knowledgeable about child development than are adult mothers; and research also indicates that teen parents generally underestimate social, cognitive, and language functioning and overestimate the attainment of developmental milestones.[38] EHS providers in the working session also reported that teenage mothers perceive their infants' temperaments as more difficult than adult mothers do.

Participants in the working session also reported that teen parents are not always aware of early intervention services, and that not all teen mothers with infants and toddlers in need of early intervention services are receiving such services. To complicate matters further, at the working session, EHS providers reported that teens may be more reluctant than older mothers to have their child identified as having a cognitive delay or disability. These factors make EHS providers well situated to facilitate those connections. The *Children with Disabilities in Early Head Start* report called for further examination of how Early Head Start and Part C partners could jointly examine barriers to enrolling children at greatest risk—including those in teen parent families—into the Part C system.

Teen parents often fear the early intervention system because of their own recent or current experiences in special education and their feelings that their babies are reflections of themselves. EHS providers report that teens may not understand the importance of early intervention services for their children. Stronger Part C partnerships that take into account the specific issues involved in dealing with teen parent families may produce improved outcomes.

Health insurance and medical expenses for teens can create barriers as well. Even when teen parents have access to health insurance, required co-pays may pose a financial burden.

While data on the effect of EHS on children with disabilities is limited, there is data related to Bayley MDI scores, which may provide some helpful information about cognitive disabilities. Children who score under 85 on the Bayley MDI are classified as "at risk," as a low score may correlate with a cognitive delay or disability.[39] The *Making a Difference* study found that EHS participation led to reductions in the proportion of children of teenage mothers who received scores below 85 on the Bayley MDI.[40]

The Hilton/Early Head Start Training Program (http://www.specialquest.org) is a public-private partnership between the Conrad N. Hilton Foundation and the Head Start Bureau. The program is designed to support the inclusion of infants and toddlers with disabilities and their families in Early Head Start (EHS), Migrant and Seasonal Head Start (MSHS), and other early care and education programs, in collaboration with partner organizations. SpecialQuest, the heart of the program, consists of four years of sequential trainings delivered to teams consisting of a family member of a child with a disability, an administrator, an early interventionist, a child care partner, an EHS/MSHS staff person, a disability services coordinator, and a Head Start staff person. Each team has a Learning Coach to facilitate and provide follow-up support. The primary activities include conducting SpecialQuests—intensive, interactive, three-day trainings—using a skill-building curriculum and providing onsite follow-up to support teams in implementing action plans developed by SpecialQuest Learning Coaches.

Additionally—as discussed earlier—EHS has a positive impact on teen parents' ability to appropriately parent and on the social-emotional behavior of children While this evidence is not specific to disability, it could bode well both for teen parents with disabilities and for teen parents of children with disabilities. Again, this is important for preparing children for school—a child's chances for success can be strengthened by emotional and academic support and by supporting the parent as the child's first educator.

Next Steps for EHS to Better Serve Teens

The CLASP EHS working session and the research around teen parent families in EHS point to a number of recommendations. These recommendations explore how a variety of programs can partner with EHS in order to ensure that this special population can be well served. EHS has shown promise for serving teen parent families. Collaboration with other programs—along with expansion of EHS at the state and federal levels—should be encouraged and supported.

1. Increase Collaboration and Partnerships with Programs Serving Teen Parent Families

Partnering with the child welfare system

The Office of Head Start should support collaboration grants focused on teen parents in EHS and child welfare. As reported above, teen mothers in EHS are less likely to use spanking and improve other parenting skills.[41] While EHS has paid some attention separately to its interaction with teen parents and with the child welfare system, there is little indication that it has looked

much at how to deal with both concurrently. The collaborative projects already in existence underscore the overlap between the goals of child welfare agencies and EHS. However, to work specifically with teen parents provides an added layer of complexity, which should be addressed through specific grant programs focused on teen parents and child welfare. To specifically and successfully serve teen parents, programs need to address a number of issues that may not be present in older parents' lives, such as school year schedules, adolescent mental health, and issues that arise when someone other than the birth parent (such as a foster parent or grandparent) is a child's temporary primary caretaker.

State legislation can support collaborations. In 2004, California enacted the Teen Parents in Foster Care Act, which specifically noted that "babies born to dependent teen parents are more likely to be separated from their birth families than babies born to teen parents who are not in the dependency system." Among other things, the act requires that, to the greatest extent possible, teen parents be provided with access to services, targeted to this population, the purpose of which is to support and develop both the parent-child bond and "the minor parent's ability to provide a permanent and safe home for the child." The act lists examples of these services as including, but not limited to, child care, parenting classes, child development classes, and frequent visitation.[42] Existing data from the *Making a Difference* study and forthcoming data (from both the follow-up to *Making a Difference* and the evaluations of the EHS/CWS initiatives) will likely allow EHS to provide sufficient evidence of its overlap with child welfare goals; and laws such as the one passed in California will provide perfect opportunities for the child welfare system to collaborate, specifically around teen parent families, with Head Start State Collaboration Offices and individual programs.

Partnering with the Disability and Early Intervention System

Early Head Start programs should develop partnerships to help identify and reach out to teen parents with disabilities. Both teen parents and their children are at risk for developmental issues. Many teen parents have disabilities themselves, creating a number of risk factors for their children..[43] Since EHS programs are not required to and generally do not collect data about parents who may have a disability, it is unknown how many parents or teen parents in those programs have disabilities. However, the information can be critical in addressing the needs of the entire family.

Under federal law, teen parents who have a disability and are still in school must have a specialized education plan—either an Individualized Education Plan (IEP) or a 504 Plan—to meet their needs.[44] As parental education may be a key factor to family stability and child health, EHS programs have an interest in and are in a unique capacity to assist with parents' education. The lack of information about teen parents with disabilities and about their rights may be leading to failures to address and account for the effect of parental disabilities on childhood development.

The Office of Head Start should support grants to facilitate collaborations between EHS programs serving teen parents and programs with expertise in adolescent disability. The SpecialQuest collaboration demonstrates how systems can work together to create models that meet the specific needs of children and families. Outside agencies with experience working with teens with disabilities can collaborate with EHS to offer assistance in a variety of forms:

ensuring that education plans are being followed, connecting parents to advocacy or support services, or merely understanding how parents' specialized needs and education programs may affect their parenting.

Better collaboration at the federal level between EHS and Part C is needed to support local partnerships. EHS Programs serving children of teen parents often develop strong, positive relationships with the parents and are in a unique position to facilitate access to early intervention services for children of teen parents. Part C programs may have difficulty addressing the issues of children with teen parents; a coordinated effort is needed. Strong partnerships are critical and should include not only EHS and Part C programs but also Head Start, special education, and disability advocacy resources.

Teen parents need continued support to advocate for their children and needed early intervention services. Teen parents, especially those with cognitive disabilities, may need added support to advocate for special services for their child with a disability as they transition out of EHS and Early Intervention services. A parent who is young and/or has a disability may be in an especially difficult position to obtain the services that the child needs – for example, services that may be available through insurance programs.

EHS programs can facilitate relationships in the medical community and help provide information to teen parents about the medical needs of their children with disabilities. While health care issues may exist for many parents, teen parents of children with disabilities are likely to experience the health care system more acutely than other parents—they may be in more situations requiring parental decision making, and they may face specific issues around consent that adult parents do not encounter. The legal ambiguity resulting from a teen's age can be difficult. While teens may legally be empowered to make medical, educational, and mental health decisions (related to disability) for their children, they may not legally be able to do so for themselves. The same legal ambiguity can affect the teen's lack of knowledge about a child's disabilities in general. Teens' lack of knowledge is sometimes due to the fact that they are not the primary caregivers, at least not for the purposes of medical attention: in some cases, the teen's parents receive and analyze information regarding the disability of their grandchild.

At the CLASP working session, EHS providers also indicated that teen parents often report negative experiences with physicians in gathering information about their child's condition. The physicians might not talk with the mother but instead focus on the grandparent or on a professional in a support role to her. Teen mothers feel "put down," unacknowledged, and disrespected by doctors and other professionals.

There are several steps that the Office of Head Start could take to help address these issues by facilitating these relationships:

- Head Start should train EHS providers on how to address the "age of consent" issue, as this can affect the services that a teen may choose for a child. However, because age of consent laws are almost always state specific, regional partnerships will be critical.[45]

- Head Start should clarify for providers the law and policy regarding the provision of information regarding disability when the child is in a third party's physical or legal custody.

The Office of Head Start should partner with training programs to address the lack of child mental health specialists trained to work with teen parents. Nationwide, there are very few professionals trained as specialists in early childhood mental health. The number of professionals who are also trained in working with teen parents is even lower. There is a significant need for these specialists to work with EHS programs, to serve children and parents with disabilities relating to mental health. Early Head Start should work to help programs establish links with adolescent specialists, whether through partnerships with educational institutions or through other methods.[46]

Partnering with Other Community Organizations

The Office of Head Start should promote partnerships with programs serving teen parent families. Because teens present unique challenges, external programs could provide EHS with more training on working with teen parents on a variety of issues: teen parent development and mental health; adolescent disability; sexual abuse, child abuse, and domestic violence; and differences between teen and adult cognitive development. EHS programs would benefit from access to experts in these areas, and collaborators would benefit as well from the services provided by EHS.

Local EHS programs should be encouraged to form partnerships with the schools serving teen parents. Because many teen parents are in school, it is critical that EHS programs understand the complications that school attendance creates for teen parent participation in EHS. Coordination between EHS programs and high schools may be difficult during summer and other breaks, during which there may be significant lapses in services provided through the school, including transportation. Collaboration in devising schedules could maximize the benefits both of EHS and of the collaborating program.

In addition, graduation from high school may result in a loss of supportive services. Teen parents often graduate before their children turn three, losing any link between EHS and the high school, as well as the close relationship between the program personnel and the teen.

Therefore, the Office of Head Start may consider the following:

- Provide guidance and technical assistance, as well as adequate resources, to help EHS programs that serve significant numbers of school-enrolled teen parents provide services during the summer and other breaks when school-based providers of these services may not be available. Such services might include home visits, transportation, counseling, and mental health services.

- Help EHS programs develop transition plans for teens and their children as the teen parents move into postsecondary education or work and their children move into Head Start, child care, and other pre-kindergarten programs. Transition plans could help provide teen parent families with consistent access to services.

2. Improve Data Collection and Community Assessments

The Office of Head Start should include parental age in the data collected in the annual Program Information Report (PIR). Currently, EHS programs collect little program-wide data about the ages of parents in the program, other than the number of pregnant teens involved in EHS. Ideally, data would be in collected in a way that allows for comparisons with other programs. In order to avoid significant increases in data collection for EHS programs, the PIR should ask only for data on the number of mothers under age 18 and under age 20.

The Office of Head Start should include funding for long-term evaluations of collaboration grants. Funding should be provided to allow programs that collaborate with EHS to collect data on children of teen parents—to be used not as an indicator as to whether individual EHS programs are meeting their goals but as a means of determining ways partners can capitalize on partnerships with EHS. For example, do partnerships between child welfare agencies and EHS, especially in the EHS/CWS Collaborations, lead to fewer substantiated reports of abuse and neglect involving teen parent families? Do children of teen parents in foster care who are involved in these collaborations spend less time in foster care? Do these programs reduce the number of placements that foster children—whether teen parents or the EHS children themselves—experience? Do collaborations have a positive effect on families that include teen parents who are likely to "age out" of foster care? Do collaborations improve parenting behavior among teen parents with disabilities?

Evanston Early Head Start is a program funded for 88 infants and toddlers and prenatal women in Evanston, Illinois. The program consists of the Child Care Network of Evanston—the grantee—and two child care partners: the Infant Welfare Society of Evanston and the Child Care Center. The program has two center-based programs and five family child care homes. One center is Teen Baby Nursery, which serves the infants and toddlers of teen parents and prenatal teens exclusively. Teen Baby Nursery serves 16 teens and their babies and at least six prenatal teens. The program works extensively with EHS, the high school, the health department, the elementary school, and other community social service agencies. The goals of the program are to support teens while they finish high school, to teach and support them to become better parents, and to discourage them from having a subsequent pregnancy while still in school. All teens who participate in the program must comply with the program components, such as being in school or a GED program and attending parenting support and education classes. Family support includes the areas of child development, parenting skills, early literacy, poetry writing, and subsequent pregnancy prevention. Most recently, a new component was added to focus on the parent-child relationship through an intensive therapeutic playgroup with four dads and four therapists. The graduation rate is extremely high, and the second pregnancy rate is very low. The program has been in existence for 16 years.

Improve community assessments to identify the needs of teen parent families. Participants in the CLASP working session underscored the importance of community assessments. Community

assessments are conducted prior to implementing new EHS programs (and again once every three years) to determine the areas of need in the community. To a significant degree, community assessments dictate the structure of EHS programs.[47] Participants felt that these assessments often miss the level of need among teen parents in a community. While there could be a number of reasons for this, it is perhaps due primarily to a disconnect between the teen parent service providers and the early education providers and early intervention providers. By examining how successful programs have conducted accurate community assessments, and by issuing guidance and offering trainings, Head Start can help local communities develop relationships with providers who can help accurately assess needs related to teen parents in the community. By reaching out to existing EHS providers, programs serving teen parent families can help programs conduct accurate assessments every three years.

3. Increase Support for Teen Parent Families in EHS

Teen parents should be included as a group in need of special focus within pending EHS legislation. Congress is currently looking at legislation to reauthorize Head Start and EHS. The bills contain numerous amendments to remove barriers to Head Start and EHS. For example, they would require that Head Start (including EHS) collect data, develop best practice standards, and develop a report for Head Start and EHS specifically relating to children in foster care, as well as homeless, migrant, and highly mobile children. The bills would also prioritize homeless children for enrollment and authorize funds for outreach to homeless families and others. But the proposals make no mention of the special issues of teen parents.[48] The fact that teen parents have significant risk factors should also be specifically addressed. In addition, future proposals should increase funding sufficiently enough so that programs may offer targeted services to each of these important groups.

The Office of Head Start should develop best practices and training to help programs recruit and retain teen parent participants. Teen parent families are different from other families. So whether through regulations or through other guidance, best practice standards should be developed, outreach should be conducted, and data should be collected related specifically to *teen parents* involved in collaborations between EHS and other partners. For example, EHS program standards require monthly average daily attendance rates for children in center-based programs. While the program standards encourage contacts around attendance to be "sensitive to any special family circumstances influencing attendance patterns," Head Start should consider providing guidance around specific approaches that would increase the number of children of teen parents who successfully continue in the program.[49]

Conclusion

Families of teen parents face unique challenges. Programs that are able to successfully assist these families in achieving goals such as improved parenting skills, healthy child development, and increased economic opportunities should be supported. Support must include funding but must focus also on improving program policy and practice, in order to ensure that the programs achieve the greatest impact possible. While the special promise of EHS to families of very young children is well known, the fact that EHS has also been shown to positively impact teen parents

and their children has not been highlighted. This is a finding that deserves more support and more study. If communities can capitalize on the special benefits EHS provides to this population, high risk teen families stand to benefit greatly. However, with only 2.5 percent of eligible children currently served through EHS, increased funding is needed for a broad-based impact on young children, including those of teen parents.[50]

CLASP EHS Teen Parent Working Session Program Participants

EHS service programs

Child Incorporated has been Early Head Start Grantee for Travis County, TX, since 1996. It is located in an urban community serving approximately 1,802 Head Start participants and 123 EHS children, of which 15 are identified as teen parents. One goal of the project is to prepare children for school by integrating early care and education services to high risk children with community partners such as the Independent School District, Head Start and Child Care (non-profit, for profit, faith based). The program is available during summer for teen parents attending summer school, or who are working full time and expected to return to school in the fall. Child Inc.'s teen parents receive comprehensive social services support and parenting education including in the Parents as Teachers (PAT) 0-3 curriculum. Child Inc. also has case management responsibilities for the teen including oversight of social service or special need referrals and oversight of school attendance and performance.

El Nido EHS serves pregnant women and children birth to three in South Los Angeles, CA, area. El Nido is funded for 60 slots, ten are assigned to expectant mothers and at least seven are designated to children with disabilities. El Nido currently serves 40 teen pregnant or parent-child families. El Nido is a home based model program and provides weekly visits in addition to bimonthly socializations. Its services include 10 week mental health group support cycles, a father's group, grandmother's circle, and job training seminars. El Nido Early Head Start is part of a greater organization serving teens in the Los Angeles County that is El Nido Family Centers. The EHS program collaborates with CAL Learn and Adolescent Family Life Programs to better serve the teen parents and mothers to be enrolled in the program.

Evanston Early Head Start in Evanston, IL, is a program funded for 88 infants and toddlers and pre-natal women in Evanston, Illinois, which is a suburb bordering Chicago. The program consists of Childcare Network of Evanston, as the grantee, and two childcare partners- Infant Welfare Society of Evanston and Childcare Center. The program has two center-based programs and five family childcare homes. One center is Teen Baby Nursery which exclusively serves the infants and toddlers of teen parents and pre-natal teens. Teen Baby Nursery serves 16 teens and their babies and at least 6 pre-natal teens. The program works extensively with Early Head Start, the high school, the health department, the elementary school, and other community social service agencies. The goals of the program are to support the teens while they finish high school, teach and support them to become better parents, and discourage them from having a subsequent pregnancy while still in school. All teens who participate in the program must comply with the program components such as being in school or GED program and attending parenting support and education classes. The family support includes the areas of child development, parenting skills, early literacy, poetry writing, and subsequent pregnancy prevention. Most recently, a new component was added to focus on the parent child relationship through an intensive therapeutic playgroup with four dads and four therapists. The graduation rate is extremely high and the second pregnancy rate is very low. The program has been in existence for 16 years.

FSU Early Head Start Program in Tallahassee, FL, targets Gadsen County, Florida and serves 68 participants. The program offers home-based educational services for 40 pregnant women, infants and toddlers (all teens are served through the home-based option) and center-based early education and child care for 28 infants and toddlers, aged 6 weeks to 3 years old. The FSU Early Head Start Program provides comprehensive health, education, social services, and family involvement services for low-income pregnant women, infants and toddlers, including those with disabilities. Services are offered year-round and include: home-based services of weekly home visits with Group Socializations held twice monthly; or full-day center-based early care and education for working parents, offered through a contract with a community partner.

The Locklin Technical Center in the rural/suburban county of Santa Rosa County, FL, is a model program which combines a teenage parenting program which Early Head Start. The goal of the Teen Age Parenting Program (TAPP) is to offer pregnant and parenting girls the opportunity to return to or continue their education and earn a high school diploma. Simultaneously, students gain practical parenting, career planning and life management skills. The TAPP student, while attending academic classes for high school graduation, has the added advantage of attending a technical training program at no cost to increase her employment and marketability while earning her diploma. Some of the services are offered by Locklin Technical Center include: parenting classes; high school diploma or GED programs; on-site vocational classes; free child care in a NAEYC child care center with Child Development Associates; catered lunches based on income; clothes closet for teens and children.

Tri-County Child and Family Development Council, Inc. Early Head Home Base program in Waterloo, IA, is a volunteer program offered to parents and their children prenatal through three years of age. Qualified home visitors offer weekly home visits for 90 minutes. We offer support to families in the areas of child development, parenting, nutrition, health, oral health, community resources and family goals. The home base program serves urban families. In fiscal year 2004 it served approximately 120 children and 35 prenatal families. Nearly 22% (26) of those families are teens. Our agency provides specialized services for teen parents. Participants 19 and younger are offered the Young Parents Together program (YPT). A home visitor from Tri-County is also the coordinator of YPT. She works 20 hours a week as a home visitor and 20 hours a week coordinating YPT. A home visitor also does outreach for prenatal families at Expo Alternative High School in Waterloo, Iowa. She provides enhanced education for the prenatal class once a week. During class they do activities that mimic an Early Head Start home visit. A few examples of these activities are: making baby's first books and doing relaxation exercises. She offers the home base program and home visits to these prenatal teens.

Tri-County Community Action Program (TCC), located in three counties in rural Central MN, serves pregnant families through a Home-Visiting model. Staff play the role of advocate, case manager, and mentor with the primary goal of getting families to a place that is stable where they can sustain a life style that is not crisis driven. Staff have access to ongoing mental health support, receive a lot of training on their role within the

context of working with the family, spend several hours a year in professional development programs, and receive ongoing reflective supervision. The counties served by TCC are consistently ranked in the five poorest making it not uncommon to have up to 1 ¼ hours of travel time between each visit. The teen pregnancy rate is higher then the state average and this coincides with high school drop out rates and substance abuse/mental health issues. TCC serves 45-55 pregnant women from ages 12 to 21 per year which is about the program's capacity. TCC's EHS program is funded for 96 spaces federally and 21 through the state. About half of the pregnant teens we serve are from families that have had several generations living in poverty; these moms typically have the greatest familial support. The majority of the other teens are from families that have several dysfunctional attributes, these moms face greater challenges in that they have no familial support and many are "abandoned" to survive on their own.

Williamson Burnet County Opportunities Inc. (WBCO), located in rural Williamson and Burnet Counties (near Austin), TX, is a community action agency established in 1966. Children and their families are provided with comprehensive services including education, health and dental screenings, nutrition, social services, mental health evaluations and parent involvement. WBCO serves 160 infants and toddlers in four Early Head Start programs throughout the two counties.

EHS Support and Research Programs

The Hilton/Early Head Start Training Program, (http://www.specialquest.org), a public-private partnership between the Conrad N. Hilton Foundation and the Head Start Bureau, has completed the third year of a five-year grant. The program is designed to support the inclusion of infants and toddlers with disabilities and their families in Early Head Start (EHS), Migrant and Seasonal Head Start (MSHS), and other early care and education programs, in collaboration with partner organizations. SpecialQuest is the heart of the program—four years of sequential trainings that are delivered to teams consisting of a family member of a child with a disability, an administrator, an early interventionist, a child care partner, an EHS/MSHS staff person, a disability services coordinator, and a Head Start staff person. Each team has a Learning Coach to facilitate and provide follow-up support. The *primary activities include* conducting SpecialQuests—intensive, interactive, three-day trainings—using a skill-building curriculum and providing on-site follow up to support teams in implementing action plans developed at SpecialQuest by Learning Coaches.

The FSU Center for Prevention and Early Intervention Policy (http://www.cpeip.fsu.edu), whose mission is to influence public policy by enlarging the knowledge base about families and young children, is funded solely through grants and contracts, with a current annual budget of approximately four million dollars. The Center's work focuses on practices and policies which prevent poor birth outcomes, build strong families, promote maternal and child health and development, and prevent disabilities.

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[1] For example, the 2000 report *From Neurons to Neighborhoods: The Science of Early Childhood Development*, released by the National Research Council and the Institute of Medicine of the National Academies, states that relationships formed in the earliest years are the "basic structure within which all meaningful development unfolds." Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC, US: National Academy Press. pp 27-28.

[2] 2005 Head Start Program Information Reports (PIR). Early Head Start comprises only 8 percent of the total Head Start program. In 2005, 81,914 children were served through EHS, and 10,485 pregnant women received services. These numbers include 5,110 participants who were enrolled for less than 45 days. For more information on the Early Head Start program, see http://www.headstartinfo.org/infocenter/ehs_tkit3.htm. For a comprehensive overview of Early Head Start, see Lombardi J. and Bogle, M.M., *Beacon of Hope: The Promise of Early Head Start for America's Youngest Children*. Zero to Three; Washington D.C. 2004. For more information on EHS data, see _____ (2006). *Early Head Start Participants, Programs, Families, and Staff in 2005*. Washington, DC: Center for Law and Social Policy.

[3] National Women's Law Center calculations based on data from the U.S. Head Start Bureau on the number of enrolled preschoolers and Census Bureau data on children in poverty by age one in 2004.

[4] The 2006 federal poverty level for a family of four in the 48 contiguous states is $20,000. *Federal Register*, Vol. 71, No. 15, January 24, 2006.

[5] This would include, for example, a family receiving Temporary Assistance for Needy Families (TANF).

[6] See, for example, Giedd, J.N., Blumenthal, J., Jeffries, N.O., Castellanos, F.X., Liu, H., Zijdenbos, A., Paus, T., Evans, A.C., & Rapoport, J.L. (1999). Brain development during childhood and adolescence: a longitudinal MRI study. *Nature Neuroscience*, 2(10):861-863.

[7] 2006 Head Start Program Information Reports (PIR).

[8] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[9] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[10] Children who score below 85 on the Bayley Mental Development Index (MDI) of the Bayley Scales of Infant Development are considered developmentally at-risk.

[11] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[12] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[13] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[14] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[15] 45 CFR § 1305.2 (l).

[16] CLASP analysis of 2006 Head Start Program Information Reports (PIR) (reflective of the 2005-2006 program year)

[17] As of 2003, federal law requires all children under the age of three who have a substantiated case of child abuse or neglect to be referred to early intervention services (42 U.S.C. § 5106a (b)(2)(A)(xxi)). The Child Abuse Prevention and Treatment Act (CAPTA), as reauthorized by the Keeping Children and Families Safe Act of 2003, requires referral of families with substantiated abuse or neglect cases to be referred to early intervention services funded under Part C of the Individuals with Disabilities Education Act http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/capta.htm.

[18] Robert M. Goerge and Bong Joo Lee, *Abuse and Neglect of the Children, in Maynard, Rebecca A., (Ed.), Kids Having Kids: Economic Costs and Social Consequences of Teen pregnancy*, Washington: Urban Institute, 1997. at 205.

[19] Mary D. Overpeck, Dr. P.H., Ruth A. Brenner, M.D., M.P.H., Ann C. Trumble, Ph.D., Lara B. Trifiletti, M.A., and Heinz W. Berendes, M.D., M.P.H. "Risk Factors for Infant Homicide in the United States" The New England Journal of Medicine -- October 22, 1998 -- Vol. 339, No. 17.

[20] Bong Joo Lee and Robert M. Goerge "Poverty, Early Childbearing and Child Maltreatment: A Multinomial Analysis" University of Chicago, 1999.

[21] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004* (Washington, DC: U.S. Government Printing Office, 2006).
[22] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *AFCARS Preliminary Estimates for FY 2005 as of September 2006 (13).* (Washington, D.C. 2006); Wulczyn, F., Hislop, K. B., & Harden, B.J. (2002). The placement of infants in foster care. *Infant Mental Health Journal*, Vol. 23 (5), 454 – 475.
[23] For a good overview of the overlap between teenage pregnancy and foster care, see Love, L.T., McIntosh, J., Rosst, M., and Tertzakian, K. (2005). Foster Hope: Preventing Teen Pregnancy Among Youth in Foster Care. Washington, D.C.: National Campaign to Prevent Teen Pregnancy. Available at http://www.teenpregnancy.org/resources/reading/pdf/Fostering_Hope.pdf. Multiple studies have found the high rates of domestic violence, physical, and sexual abuse suffered by teens who become or are pregnant or parenting. Center for Impact Research (2000, February). *Domestic Violence and birth control sabotage: A report from the teen parent project.* Chicago, IL: Author. Stock, J.L., Bell, M.A., Boyer, D.K., & Connell, F.A. (1997). Adolescent pregnancy and sexual risk-taking among sexually abused girls. *Family Planning Perspectives, 29*(5), 200-203, 227. Liederman, S. & Almo C. (2001) *Interpersonal Violence and Adolescent Pregnancy: Prevalence and Implications for Practice and Policy.* Center for Assessment and Policy Development. Available at http://www.healthyteennetwork.org.
[24] Andrea Sedlak & Diane Broadhurst, *Third National Incidence Study of Child Abuse and Neglect*, (Washington, DC: U.S. Department of Health and Human Services, 1996).
[25] Cited in Hebbeler, K., Wagner, M., Spiker, D., Scarborough, A., Simeonsson, R., & Collier, M. (2001). National early intervention longitudinal study: A first look at the characteristics of children and families entering early intervention services. Menlo Park, CA: SRI International.
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[27] Elizabeth Thompson Gerhsoff, Corporal Punishment by Parents and Associated Child Behaviors and Experiences: A Meta-Analytic and Theoretical Review Psychological Bulletin Copyright 2002 American Psychological Association, Inc. 2002, Vol. 128, No. 4, 539–579, 540, available at http://www.endcorporalpunishment.org/pages/pdfs/Gershoff-2002.pdf.
[28] Whitman, T.L., Borkowski, J.G., Schellenbach, C.J., & Nath, P.S. (1997). Predicting and understanding developmental delay of children of adolescent mothers: A multidimensional approach. *American Journal of Mental Deficiency, 92*(1), 40-56.
[29] See http://www.teenpregnancy.org/whycare/sowhat.asp
[30] See http://www.ed.gov/about/reports/annual/osep/2001/section-ii.pdf
[31] See http://www.ed.gov/policy/speced/guid/idea/idea2004.html
[32] According to the federal Office of Head Start, "the Performance Standards are the mandatory regulations that grantees and delegate agencies must implement in order to operate a Head Start and/or Early Head Start program. The standards define the objectives and features of a quality Head Start program in concrete terms; they articulate a vision of service delivery to young children and families; and they provide a regulatory structure for the monitoring and enforcement of quality standards." For more information, see http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Requirements.
[33] 45 C.F.R. § 1305.6(c): At least 10 percent of the total number enrollment opportunities in each grantee and each delegate agency during an enrollment year must be made available to children with disabilities in Section 1305.2(a).
[34] In the 2005 program year, 46 percent of EHS children with a disability were not diagnosed until they participated in Early Head Start. _____ (2006). *Early Head Start Participants, Programs, Families, and Staff in 2005*. Washington, DC: Center for Law and Social Policy.
[35] National Early Intervention Longitudinal Study. http://www.sri.com/neils/EFI1report.pdf at 18. This is greater than the 9 percent of families with children headed by a parent who gave birth as a teen. Notably, only 2 percent of the *partners* of the primary caregivers receiving Part C services were teens. National Early Intervention Longitudinal Study. http://www.sri.com/neils/EFI1report.pdf at 21.
[36] U.S. Department of Health and Human Services. "Research to Practice: Children with Disabilities in Early Head Start:" *Early Head Start Research and Evaluation Project.* 2003. http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/children_disabilities/children_disabilities.pdf

[37] A score of 70 on the Bayley MDI makes a child categorically eligible in every state for Part C services. Id., citing Shackelford, J. (2006). State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA (NECTAC Notes No. 21). Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center. Available at http://www.nectac.org/%7Epdfs/pubs/nnotes21.pdf.

[38] Osofsky, J.D., Hann, D.M., & Peebles, C. (1993). Adolescent parenthood: Risks and opportunities for mothers and infants. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (1st ed., pp. 106-119). New York: Guilford.

[39] Other factors could be causing a low Bayley score; a disability diagnosis cannot be made on this measure alone.

[40] U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.

[41] *Head Start Impact Study: First Year Findings* Administration for Children and Families • U.S. Department of Health and Human Services, June 2005 available at http://www.acf.hhs.gov/programs/opre/hs/impact_study/reports/first_yr_finds/first_yr_finds.pdf. Although Head Start was not designed specifically to serve the needs of teenage mothers, these findings suggest that access to the program can have beneficial effects in reducing children's risk for punitive discipline practices, although results of studies of efforts to improve the parenting skills of young low-income mothers have had mixed results.

[42] California Senate Bill 1178 (2004). Information on the Teen Parents in Foster Care Act can be found at http://dcfs.co.la.ca.us/Policy/FYI/2005/FYI0501TeenParentsFosterCareACT.doc.

[43] For a brief analysis of the correlation between teen parents and special education, see the CLASP Brief "TANF & Teen Parents with Disabilities" November 2001, available at http://www.clasp.org/publications/tanf_and_teen_parents_with_disabilities.pdf. The report discusses two small, local studies that suggest correlations between various disabilities and teen pregnancy and parenthood.

[44] Both the Individuals with Disabilities Education Act (IDEA) and Section 504 are federal laws designed to protect the rights of individuals with disabilities in programs and activities that receive federal funds from the U.S. Department of Education. Students are eligible for an individualized education plan if they have any of the following conditions: autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment including blindness. 20 USC 1400, et. seq. The counterpart for infants and toddlers from birth through age two is early intervention services (Part C), delivered through an individualized family service plan. Section 504 covers any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Major life activities include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794 (Section 504).

[45] For specifics on state minor consent laws, see English A, Kenney KE. *State Minor Consent Laws: A Summary.* 2nd ed. Chapel Hill, NC: Center for Adolescent Health & the Law, 2003.

[46] 2005 PIR Data.

[47] 45 CFR §1305.3.

[48] H.R. 2123, "The School Readiness Act of 2005" and S. 1107, "The Head Start Improvements for School Readiness Act."

[49] 45 CFR §1305.8 (b)

[50] National Women's Law Center calculations, based on data from the U.S. Head Start Bureau preschoolers and Census Bureau data on children in poverty by age one in 2004.