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| Massachusetts Pregnant & Parenting Teen Initiative |
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| 2010-2020 | Massachusetts Department of Public HealthOffice of Sexual Health & Youth Development |



Executive Summary

The birth of a child can be a catalyst for a young person to achieve educational or employment goals and address their social/emotional health needs. Yet many young parents in Massachusetts have complex needs as a result of housing instability, histories of trauma, involvement in state systems of care, and behavioral health concerns. Young parents require coordinated support across multiple systems that build on their strengths.

**MPPTI Program Snapshot**

**What is the MPPTI Program Model?**

● Multidisciplinary, team-based case management for young parents aged 14-24 in five MA communities

● Two generation approach that addresses the needs of both young parents and their children

● Flexible, data-driven approach that emphasizes healthy relationships and social/emotional supports to build self- efficacy

**Who does the MPPTI Program serve?**

● An average of 580 participants– 280 young parents and 300 children - from 5 MA communities annually

**MPPTI bridges the gap**

● Many young families have significant unmet needs, especially related to housing and social/emotional health

● Compliance-based programs and multiple case workers hinders program engagement among young parents with complex needs

● MPPTI’s program model fills gaps in services for young parents by using a flexible approach that meets young parents where they are, emphasizes building relationships with program staff and other young parents, and allows for adaptations to meet local needs

● MPPTI participants enrolled in the program for 6+ months saw increases in employment, enrollment in education programs, and contraceptive use

The Massachusetts Pregnant and Parenting Teen Initiative (MPPTI) uses a two-generation model to provide case management to expectant and parenting adolescents using a positive youth development approach that builds on participants' strengths. The program goal is to increase life opportunities and enhance family stability among young families in selected Massachusetts communities through supporting educational attainment and employment; improving access to health services; supporting child development; and promoting healthy relationships.

MPPTI uses real-time data and tracking of performance measures, which has allowed for accountability and process improvement over the course of the program. As a result, MPPTI has been able to identify gaps in service for young families in Massachusetts and work toward adapting the MPPTI program model to fill those gaps. MPPTI meets the needs of young families by employing a flexible program model; building relationships between program participants and staff in order to build trust; and emphasizing social/emotional supports so that parents can care for themselves and their children while also working toward achieving educational and employment goals that lead to family self-sufficiency.

MPPTI serves an average of 580 individuals - 280 young parents and 300 children – annually. Many MPPTI parent participants have significant needs, especially related to housing and behavioral health, often leading to disengagement from school and work. At program intake, 59% of participants report having unstable housing and 54% are not in school and not employed. MPPTI participants engaged in the program for 6 months or more typically see increases in school enrollment, employment, use of a contraceptive method, and progress toward achieving academic and/or career goals.

Massachusetts Pregnant & Parenting Teen Initiative

Massachusetts Department of Public Health
Office of Sexual Health & Youth Development

The Massachusetts Pregnant and Parenting Teen Initiative (MPPTI) is a comprehensive case management program supporting young parents between the ages of 14-24 in the five Massachusetts communities of Chelsea, Lawrence, Holyoke, New Bedford, and Springfield. The birth of a child can be a catalyst for a young person to achieve education or employment goals and address their social/emotional health needs[[1]](#endnote-1) and to help them achieve these goals, young parents often require coordinated support that builds on their strengths.

**“It should not be by chance that young people are stable.”**

**-MPPTI provider**

MPPTI began in 2010 with an award from the federal Pregnancy Assistance Fund (PAF) to the Massachusetts Department of Public Health (MDPH). Prior to its inception and throughout the entire MPPTI program period, MDPH has used the best available data and collaborated with community-based partners to develop and adapt programming to best meet the needs of participants. As a result of this breadth of data collection, MDPH has identified both effective strategies for meeting the needs of young parents and significant unmet needs.

***Needs of & Gaps in Service for Young Parents in Massachusetts***

**Many young parents in Massachusetts have complex needs as a result of housing instability, histories of trauma, involvement in state systems of care, and behavioral health concerns.**

Many young people living in the communities MPPTI serves experience inequitable health and socioeconomic outcomes. All 5 MPPTI communities have teen birth rates between 3-4 times higher than the state rate, all have family poverty levels that are more than twice the state level; 4 out of the 5 communities have unemployment rates higher than the state; and all have high school dropout rates higher than the state average (Appendices A and B). Health behaviors – including sexual behavior - are shaped by a broad range of social, environmental, and economic conditions, which occur in the context of larger societal structures. Histories of racism, redlining, and maltreatment/neglect from the medical community are all contributing factors to these inequities, particularly for young people of color[[2]](#endnote-2),[[3]](#endnote-3).

**Young Parents in MA**

-The MA Hispanic teen birth rate is 8x higher than the MA White non-Hispanic rate and the Black NH rate is 3x higher than the White NH rate\*

**-**MA has the 2nd highest number of homeless families with children in the US\*\*

-Mothers aged 15-19 in MA are 22% less likely to receive adequate prenatal care compared to all MA mothers\*

-Among women aged 15-19 giving birth in MA, 12% are having their 2nd or higher child\*

MPPTI providers identified a critical need for behavioral health and social support for young families early in the program. These needs intersect with other complex challenges that many young families face, such as histories of trauma and/or social isolation. Young people living with disabilities[[4]](#endnote-4), homeless youth[[5]](#endnote-5), youth in foster care[[6]](#endnote-6), youth of color[[7]](#endnote-7), and youth who have experienced sexual abuse[[8]](#endnote-8) all experience pregnancy and parenting during adolescence at higher rates than other youth. Adolescent parents who are homeless may have significant mental health needs and are more likely to experience postpartum depression than other populations**[[9]](#endnote-9)**. Histories of trauma, PTSD, depression, and sexual abuse are high among unaccompanied refugee minors[[10]](#endnote-10).

\* Massachusetts Births 2017 Boston, MA: Registry of Vital Records and Statistics, Massachusetts Department of Public Health. November 2019. Retrieved from: <https://www.mass.gov/lists/birth-data>

\*\* US Department of Housing and Urban Development. (2018). *The 2018 Annual Homeless Assessment Report to Congress.* Retrieved from: <https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>

**Housing instability is a critical concern for young families in Massachusetts.**

At program intake, 15% of MPPTI participants are homeless (defined as living in a shelter or a public place) and 59% are experiencing housing instability (defined as living in a shelter or public place; living in a foster home; living temporarily in a friend or relative’s home, or having a housing situation that is not secure). Many young parents facing housing instability in the state during 2011-2014 were placed in hotels outside of their communities. The result was a number of young women and their children isolated from their social/emotional support networks and facing significant transportation barriers to education and employment opportunities. The combination of this isolation in conjunction with living in a hotel puts many young parents at risk of sex trafficking and other forms of exploitation. Since 2015, the number of homeless families housed in hotels has decreased as families were placed in temporary shelters, but the need for long-term housing has not decreased[[11]](#endnote-11): Massachusetts has the second highest number of homeless families with children in the US and the number of homeless families with children in MA nearly doubled from 2007-2018[[12]](#endnote-12). There continues to be especially high needs for housing in the Springfield area.[[13]](#endnote-13)

**“Working with young people…can be difficult: They move a lot; their phones aren’t working anymore; they’re homeless; they’ve got stuff going on, and; they can’t be in one place long enough with you emotionally to connect with something. A lot of our folks have experienced multiple traumas in life and find trust very difficult. And the work is challenging.”**

**-MPPTI provider**

**There are gaps in services for young families with complex needs across the Commonwealth.**

Based on MPPTI referral and enrollment patterns, and focus groups conducted among young parents in Massachusetts, MDPH learned that there are gaps in services for some young parents in the Commonwealth.

***Program eligibility restrictions*** – A MDPH needs assessment found that there are few programs serving young parents between the ages of 20-24 and parents under the age of 19 having a second or higher order child. The programs that do exist are not available statewide. In addition, many programs serve young families with infants, but there are fewer programs serving young families with children who are preschool or school-aged. In Massachusetts, 12% of births among 15-19 year olds and 41% of births among 20-24 year olds are second or higher order births.[[14]](#endnote-14) While teen parents aged 15-19 often are eligible for programs that help them work toward completing their education and parenting their children, many young parents aged 20-24 giving birth were teen parents and continue to require support in accessing education, employment, health care, and early education and care for their children.

***Multiple case workers -*** Many young parents have 4-6 case workers across multiple state agencies with differing program eligibility and required documentation[[15]](#endnote-15). Negative experiences with health care providers and/or fear of being judged or stereotyped by providers may impact youth seeking or remaining engaged in services[[16]](#endnote-16). MPPTI community-based staff reported that they have to reach out to the same young parents multiple times before a relationship that is strong enough to talk about topics like education/ employment goals, parenting, behavioral health, and housing can be built. Having multiple case workers hinders the development of trusting relationships and may interfere with young parents remaining engaged in programming and/or being upfront with their case workers about what their needs are.

**“I thought…I didn’t really vibe with professional people because I feel like they are not down to earth. I felt like I had to put on a mask with these people with all smiles…that’s why I wasn’t open to help at all from anyone.”**

**-MPPTI participant**

***Positive youth development approach*** - Many programs serving young families focus primarily on child health and development. While this important need must continue to be prioritized, programs serving young families often do not prioritize services to the parents. Services geared toward connecting young parents with education and employment opportunities, access to quality health care, and addressing behavioral health concerns can provide long-term family stability.

***Young fathers -*** Because young parent programs have historically targeted services toward young mothers, there is limited data on the needs of young fathers and a limited evidence base on effectively engaging young fathers in programming. Recruiting and retaining young fathers in programming continues to be both an ongoing need and a challenge.

***Compliance-based requirements -***Some programs restrict eligibility to participants who can commit to prescribed attendance requirements up front or must obtain jobs or reach other goals according to predetermined timelines. Young parents with the greatest needs – especially in terms of housing and social/emotional needs – may not be able to meet compliance-based requirements within the allotted amount of time if they are struggling with housing and childcare, a history of trauma, the stresses of being a parent, and a lack of a strong social/emotional support network all at the same time.

***MPPTI Program Model***

Although MPPTI has evolved in its approach since 2010, the core goals and services have remained constant. MPPTI uses a multidisciplinary team model to provide case management to expectant and parenting adolescents using a positive youth development approach that builds on participants' strengths. Services are tailored to participants' individual needs and provided at community locations or home visits. The program goal is to increase life opportunities and enhance family stability among young families in selected communities through:

**MPPTI Core Services:**

* Health education & counseling
* Behavioral health support
* Child health & development support
* Referrals to primary & reproductive health care
* Education & employment support
* Parenting support
* Concrete supports (food, transportation, benefits)
* Increasing educational attainment and employment
* Improving access to and utilization of healthcare, including sexual & reproductive health services and primary and pediatric care
* Support child development and school readiness
* Promote healthy relationships (peer, parent/child, family, and romantic)

From 2014-2017, MPPTI served 1,150 participants (588 young parents and 600 children).[[17]](#footnote-1) Demographics and characteristics of young parent participants are presented in Table 1.

**MPPTI’s program model fills gaps in young parent programming in Massachusetts.**

MPPTI uses a flexible, data-driven approach to implement a two-generation case management program emphasizing relationship-building and social/emotional supports to serve young families whose needs cannot be met with less comprehensive program models. A two-generation program model focuses on both the needs of the child and the needs of the caregiver(s) in a family[[18]](#endnote-17) – in the MPPTI program, the caregiver is the adolescent parent. Two-generation models *“emphasize education, economic supports, social capital, and health and well- being to create a legacy of economic security that passes from one generation to the next[[19]](#endnote-18).*

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| Table 1: Characteristics of MPPTI Participants at Program Entry, 2014-2017 (n=588) |
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| Age |  |
|  13-17 years | 17.5% |
|  18-19 years | 24.6% |
|  20-25 years | 57.9% |
|  |  |
| Gender Identity |  |
|  Female | 92.1% |
|  Male | 7.9% |
|  |  |
| Pregnancy Status |  |
|  Expecting | 26.6% |
|  Parenting | 73.4% |
|  |  |
| Race/Ethnicity |  |
|  Black NH | 8.7% |
|  Hispanic / Latinx | 76.8% |
|  White NH | 10.6% |
|  Other NH | 3.9% |
|  |  |
| Requires interpreter | 19.0% |
|  |  |
| Unstable housing | 59.0% |
|  |  |
| Not in school and not employed  | 54.1% |

***Flexible, data driven approach* –** MPPTI uses a data-driven approach to identify the needs of young parents and best practices for meeting those needs. Real-time data and tracking of performance measures allows for accountability and process improvement. MPPTI has continually adapted its program model to fill gaps in programming for young families in the state.

MDPH tracked MPPTI participant outcomes in relation to progress toward individualized academic and career goals, education and employment status, contraceptive choice, access to health care, housing status, and other outcomes. A notable finding was that, while participants experienced positive outcomes such as obtaining jobs, enrolling in school, and finding housing, it generally took 6 months or more of program engagement to achieve these outcomes. An exception to this was enrolling in health insurance and increasing use of a contraceptive method: these changes could be seen within 3 months of enrollment. Mean program engagement ranged from 9.6 to 18.8 months depending on the agency.

**4% increase in participants with stable housing**

Among MPPTI participants engaged in the program for 6 months or more, there was a significant increase[[20]](#footnote-2) in both contraceptive use and employment (Figure 1). Among participants engaged in the program for 9 months or more, there was an increase in the percent of participants with stable housing, but the increase was not statistically significant. Other program outcomes among participants engaged in the program for 6 months or more included:

* 58% of participants made progress[[21]](#footnote-3) toward individualized academic and/or career goals
* 18% of participants with a HS diploma or equivalent were enrolled in a postsecondary program over the course of the program
* 98% of participants were enrolled in insurance
* 71% of participants who were pregnant at intake reported attending a postpartum visit 21-56 days following the birth

***Notes:*** NH means non-Hispanic.

Drop-in or short-term programs where young parents must meet prescribed requirements meet the needs of many young families and remain crucial to providing a comprehensive support network for families across the state. However, the needs of many young parents cannot be met with short-term programming: the social/emotional needs of many young parents means that longer program models focused on relationship building and overcoming trauma may be needed to assist these young parents with meeting their family’s needs in the short-term and achieving self-sufficiency in the long-term.

***Relationship building -*** MPPTI builds relationships with young parents to engage them in programming and connect them with the services they need.MPPTI program staff report that building relationships with participants is key to engaging them in the program and getting them enrolled in direct services such as educational programs and reproductive health care.

**“I think the backbone of the model is to establish a transformational relationship between the youth worker and the mom.”**

**-MPPTI provider**

***Team-based approach*** - An important component of the MPPTI program model is a team-based approach where care for each participant is coordinated by a group of professionals. The staffing model at MPPTI-funded agencies includes a program coordinator, a community health worker (CHW) or youth worker, and a licensed clinical social worker (LICSW) or a registered nurse (RN) with a background in mental health. Providers are also required to have referral partnerships with domestic violence agencies, clinical health providers, schools and alternative education programs, and other community organizations that may fill gaps in the services provided directly by the MPPTI agency, such as housing agencies.

***Social/emotional support* -** Many young parents are isolated and can benefit from programs that enable them to build their social/emotional support networks. MPPTI offers not only referrals to clinical behavioral health counseling, but also offers support groups for young parents, art-based therapy, and social groups and outings for families. Multiple avenues for connecting both with other young parents and with program staff increase the strength of social/emotional support networks and can improve the resiliency of young parents.

# Next Steps

**Sustainability**

**“I wish all the young mothers in this whole country, in the whole world, could have this program.”**

**-MPPTI participant**

Funding from PAF was appropriated for 10 years and PAF grant funding for MPPTI ended on June 30, 2020. MDPH embarked on sustainability efforts for MPPTI beginning in 2016. These efforts have included working in close collaboration with funded community-based agencies, partners in other child and adolescent-serving programs at MDPH and other state agencies to disseminate program findings and impact; building a coalition at both the state and local levels to examine programs and services for young families with the goal of reducing duplication and improving service coordination and effectiveness; and working toward replicating and continuing the program beyond the PAF grant cycle.

***Collaborations***

In 2018, a statewide convening was held to provide space for state agencies to discuss young parent services across the state with the intention of identifying needs, gaps, and opportunities for collaboration. Following the initial convening, additional meetings were held in 2019 and the group identified potential strategies for continued future collaboration. While MPPTI can fill gaps in programming for some young families, streamlining services across state agencies would be beneficial. A shared assessment or intake form and a coordinated process for triaging referrals would be promising first steps toward more coordinated services. Additional steps could include the development of shared performance measures or joint funding of community-based agencies to provide more comprehensive services on a continuum.

***Program Replication & Continuation***

 As PAF funding came to an end in June 2020, MDPH worked closely with community-based agencies to develop plans for replicating and/or continuing provision of services using the MPPTI program model. For example, Roca Inc. in Chelsea began serving young parents as a MPPTI grantee in 2011 and in 2018 expanded their young parents program to Springfield and Holyoke using the same program model. Funding from MDPH was supplemented by additional money raised by Roca to serve a higher number of young parents.

In 2019, funded MPPTI agencies met to discuss strategies for program replication and continuation. Potential strategies included meeting with senior leadership at funded agencies to determine how elements of the program model may be incorporated into other programming at those agencies; collaborating with other local agencies to create a network of services for young families; and working with MDPH and other state agencies to identify other programs that can continue to work with the young families being served by MPPTI.

MDPH is continuing to work with internal and external stakeholders to identify strategies for sustaining MPPTI beyond the PAF grant cycle, which ended in June 2020. Current activities and next steps include:

* Giving young parents opportunities to share their stories to raise awareness about their needs, challenges, strengths, and opportunities for their families
* Raising awareness about the program via dissemination of program findings
* Continuing to work with funded MPPTI community-based agencies to increase their capacity to sustain the program through collaboration within their organizations and through building partnerships with other organizations
* Seeking additional funding to replace PAF funds
* Collaborating with MDPH programs and other state agencies to incorporate elements of MPPTI into existing programs should replacement funding for MPPTI not be available
* Continuing to work closely with internal and external stakeholders toward the goal of streamlining services for young families across the state and providing services on a continuum

Young families deserve well-coordinated services that support their individual needs while also strengthening their families and Massachusetts communities.

**Appendices**

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| **Appendix A: MA & US Birth Rate Per 1,000 Women Aged 15-19 Years by MPPTI Community and Select Race/Ethnicity, 2017** |
| Community | All Teen Births | White NH | Black NH | Hispanic |
| Lawrence | 34.5 | ---\* | ---\* | 39.5 |
| Chelsea | 36.8 | ---\* | ---\* | 46.4 |
| Holyoke | 26.5 | ---\* | ---\* | 31.2 |
| New Bedford | 30.3 | 12.8 | 57.6 | 68.1 |
| Springfield | 28.5 | 7.3 | 17.9 | 46.1 |
| Massachusetts | 8.1 | 3.5 | 11.4 | 27.8 |

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| **Appendix B: Select Economic, Health, & Education Indicators, MPPTI Communities & MA** |
| Community | Family poverty level (2017) | Unemployment level (2017) | High school dropout rate (2017-18) |
| Chelsea | 16.6% | 5.5% | 6.7% |
| Holyoke | 24.7% | 10.2% | 4.9% |
| Lawrence | 22.1% | 7.2% | 5.1% |
| New Bedford | 19.3% | 9.1% | 3.8% |
| Springfield | 24.7% | 11.1% | 5.1% |
| Massachusetts | 7.8% | 6.0% | 1.9% |

**Sources**

***Birth rates:*** Massachusetts Births 2017 Boston, MA: Registry of Vital Records and Statistics, Massachusetts Department of Public Health. November 2019. Retrieved from: <https://www.mass.gov/lists/birth-data>

***Unemployment and Poverty data:*** American Community Survey, 2017. Retrieved from: <https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml>

***High school data:*** Massachusetts Department of Elementary and Secondary Education, 2017-2018. Retrieved from: <http://www.doe.mass.edu/infoservices/reports/dropout/2017-2018/>

\*The number of births was between 1 and 4. Rates based on counts of 1-4 are not presented.

**Endnotes**

1. Dworsky, A., Morton, M. H., Samuels, G. M. (2018). Missed opportunities: Pregnant and parenting youth experiencing homelessness in America. Chicago, IL: Chapin Hall at the University of Chicago. [↑](#endnote-ref-1)
2. Rothstein, R. (2017). [*The Color of Law: A Forgotten History of How Our Government Segregated America*](https://projects.iq.harvard.edu/hksdigitalbookdisplay/publications/color-law-forgotten-history-how-our-government-segregated-america)*.* First edition. Liveright Publishing Corporation, a division of W.W. Norton & Company. [↑](#endnote-ref-2)
3. Sternm AM. (2005). STERILIZED in the Name of Public Health. Race, Immigration, and Reproductive Control in Modern California. *American Journal of Public Health*, 95(7): 1128-138. doi: [10.2105/AJPH.2004.041608](https://dx.doi.org/10.2105%252FAJPH.2004.041608) [↑](#endnote-ref-3)
4. Massachusetts Department of Public Health. (2016). *Data Brief: Massachusetts Adolescent Health. Sexual Health, Experiences, and Behaviors.* Retrieved from: <https://www.mass.gov/lists/massachusetts-youth-health-survey-myhs> [↑](#endnote-ref-4)
5. [National Conference of State Legislatures](http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx). (2019). *Youth Homelessness Overview*. Retrieved from: <http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx> [↑](#endnote-ref-5)
6. Boonstra H. (2011). Teen Pregnancy Among Young Women in Foster Care: A Primer. *Gutt*m*acher Policy Review, 14(2).* Retrieved from: <https://www.guttmacher.org/gpr/2011/06/teen-pregnancy-among-young-women-foster-care-primer#2> [↑](#endnote-ref-6)
7. Power to Decide: the campaign to prevent unplanned pregnancy. *National and State Data.* Retrieved from: <https://powertodecide.org/what-we-do/information/national-state-data/national> [↑](#endnote-ref-7)
8. Noll, J.G., Shenk, C.E., Putnam K.T. (2009). Childhood Sexual Abuse and Adolescent Pregnancy: A Meta-analytic Update. *Journal of Pediatric Psychology*, 34(4), 366-378. doi: [10.1093/jpepsy/jsn098](https://dx.doi.org/10.1093/jpepsy/jsn098) [↑](#endnote-ref-8)
9. Crawford, D. M., Trotter, E. C., Sittner Hartshorn, K. J., & Whitbeck, L. B. (2011). Pregnancy and mental health of young homeless women. American Journal of Orthopsychiatry, 81(2), 173–183. doi: 10.1111/j.1939-0025.2011.01086.x [↑](#endnote-ref-9)
10. Huemer, Julia, et al. Mental health issues in unaccompanied refugee minors, 2009. *Child and Adolesc Psychi and Ment Health*. 3 (13). doi: <https://doi.org/10.1186/1753-2000-3-13> [↑](#endnote-ref-10)
11. Schoenburg S. (2016, July 28) Massachusetts sees steep drop in homeless families housed in hotels. <https://www.masslive.com/politics/2016/07/massachusetts_sees_steep_drop.html> [↑](#endnote-ref-11)
12. US Department of Housing and Urban Development. (2018). *The 2018 Annual Homeless Assessment Report to Congress.* Retrieved from: <https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf> [↑](#endnote-ref-12)
13. Ibid. [↑](#endnote-ref-13)
14. MA Department of Public Health. (2016). Registry of Vital Records and Statistics, 2016 Birth File and Massachusetts Births 2017 Boston, MA: Registry of Vital Records and Statistics, Massachusetts Department of Public Health. November 2019. Retrieved from: <https://www.mass.gov/lists/birth-data>. [↑](#endnote-ref-14)
15. MA State Convening on Young Families. (2019). Summary of Focus Group Results, unpublished. [↑](#endnote-ref-15)
16. Harrison, M. E., Clarkin, C., Rohde, K., Worth, K., & Fleming, N. (2017). Treat me but don’t judge me: A qualitative examination of health care experiences of pregnant and parenting youth. *Journal of Pediatric Adolescent Gynecology,30*(2), 209–214. <https://doi.org/10.1016/j.jpag.2016.10.001>. [↑](#endnote-ref-16)
17. *From 2011-2013, MPPTI served a total of 1,221 participants (661 young parents and 560 children). Data from 2011-2013 cannot be combined with data from 2014-2017 due to the changes in the data collection system, so statistics in this report are for 2014-2017 participants only.* [↑](#footnote-ref-1)
18. ASCEND: The Aspen Institute. *What is 2Gen? The Two-Generation Approach*. Retrieved 24 March 2020 from: <https://ascend.aspeninstitute.org/two-generation/what-is-2gen/> [↑](#endnote-ref-17)
19. Urban Institute, Metropolitan Housing and Communities Policy Center. *Two-Generation Approach.* Retrieved 24 March 2020 from: <https://www.urban.org/policy-centers/metropolitan-housing-and-communities-policy-center/projects/host-initiative-action/designing-housing-platform-services/two-generation-approach> [↑](#endnote-ref-18)
20. Increases were measured using McNemar’s test. Change in employment was significant at p<.001 and change in contraceptive use was significant at p=.002 [↑](#footnote-ref-2)
21. Academic and career goals are identified by participants and broken down into smaller action steps. “Progress” here is defined as successfully completing at least one of the smaller action steps identified. [↑](#footnote-ref-3)