Children Having Children: The Crisis and Minnesota’s Response

by Esther Wattenberg

As the 1980s came to a close, school-age mothers were widely regarded as a troubling challenge for social programs and public policy makers. Not only did parenthood in adolescence trigger a complicated chain of events resulting in high rates of poverty and welfare dependency, but the outcome for children born to adolescents was generally poor. Almost without dissent, minor mothers were classified as “high risk” and became a source of intense concern.

Mandatory Social Service Plan

Minnesota’s response, in 1987, was a sweeping piece of legislation requiring that every minor mother in the state—whether receiving Aid for Dependent Children (AFDC) or not, whether married or not—develop a comprehensive plan with their

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county social service agency. A bulletin, based on the legislation and issued by the Minnesota Department of Human Services, instructed all eighty-seven counties on their obligations.

Every hospital in the state was required to report a birth to a minor mother to the county social service agency, within three working days of the birth. The county was directed to contact the mother and determine if she had a plan for herself and the child. The plan must consider eleven points:

1. the age of the minor parent;
2. the involvement of the minor’s parents or of other adults who provide active, ongoing guidance, support, and supervision;
3. the involvement of the father of the minor’s child, including steps taken to establish paternity, if appropriate;
4. a decision of the minor to keep and raise her child or place the child for adoption;
5. completion of high school or GED;
6. current economic support of the minor parent and child and plans for economic self-sufficiency;
7. parenting skills of the minor parent;
8. living arrangement of the minor parent and child;
9. child care and transportation needed for education, training, or employment;
10. ongoing health care; and
11. other services as needed to address personal or family problems or to facilitate the personal growth and development and economic self-sufficiency of the minor parent and child.

If the mother did not have a plan for herself and child, the county social services agency would work with her to develop a plan and provide case management services as needed. If the mother refused to plan for herself and her child or failed, without good cause, to follow through on an agreed upon plan, the county social services agency would file a petition to place the mother and child under protective supervision or, for mothers on AFDC, the AFDC grant would be transferred to a third party until compliance with the requirements were fulfilled. Later, when Minnesota implemented the Family Support Act of 1988 (federal welfare reform legislation) a further restriction was imposed that would reduce the AFDC grant for non-compliance with the education part of the plan.

Risk assessment and early intervention to forestall bleak circumstances was clearly the intent of the Minnesota response. The mandatory social service plan of 1987 slipped through without public hearings, with little legislative debate, and inconspicuous public attention. No appropriation accompanied the legislation.

How did it come about that a piece of legislation was passed which placed virtually all minor mothers in the state under protective supervision, or as some said, surveillance, without public comment? The context in which this legislation was enacted provides the key. A sense of crisis about both the size and consequences of adolescent parenting set the stage for unqualified support of the legislation.

The Demographic Data

In 1987, the year this legislation was passed, total births in Minnesota were 65,168. Of these, 4,856 or 13 percent were to minor women (under age 18). While the numbers were modest compared to national data, it was the non-marital status of these births that struck a raw political nerve. Seventy-three percent of the births to minor women were out-of-wedlock for that year. They represented one-third of all out-of-wedlock births in the state. What had changed, dramatically, was that the minor mothers were not married. Out-of-wedlock births to adolescent mothers had more than quadrupled between 1960 and 1986. The Minnesota county profiles for 1987 are instructive (see map).

The Social Context

A stream of studies of adolescent childbearing in the 1980s showed that women who begin having children as teenagers become long-term welfare recipients and that their children have poor social and psychological prospects. Although a few studies also showed in the long run some minor mothers escape the catastrophic destiny assigned them, overall a high risk designation for both mothers and their children has prevailed. The fate of fathers of out-of-wedlock children was hardly mentioned at all.

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** Amended Minnesota Statutes, 1988, section 257.33, subdivision 2.
Although the Minnesota legislature has mandated that hospitals report births to minor mothers to the county social service agency, this study found that hospitals were often unreliable in making referrals.

With the decline of federal funds during the Reagan administration, state legislatures around the country assumed responsibility for responding to the social concerns of minor mothers. Between 1985 and 1988, one-third of the states initiated legislative task forces to study the problem. Two-thirds of the states enacted legislation. By 1988, a total of 275 bills concerned with their education, health care, and social services had been enacted. A political consensus emerged, rare in social problems, that teenage mothers (only occasionally were fathers mentioned) carried a large price tag for the public treasury.

At the same time that the legislation was being passed, the debate on welfare reform was proceeding. Widespread support emerged for the idea that receiving public assistance obliges one to work toward becoming self-sufficient. For teen mothers, this social contract had a distinctive message. Completing high school and job training, and getting and holding a job were clear expectations along with providing a fit home for one's child.

This Study

What happens when the legislature mandates prescriptive, detailed, and comprehensive social service plans for every minor mother in Minnesota, without appropriating any funds to carry out the mandate? To explore this question, CURA studied the implementation process.

A structured telephone questionnaire with sixty items was developed and pretested with the cooperation of the State Department of Human Services. Questions were asked about five major areas: procedures, coordination, casefinding, follow-up, and provision of services. Telephone interviews ranging from forty-five to ninety minutes were conducted by two graduate students in the School of Social Work during the fall and winter of 1989-90. Eighty-two of Minnesota's eighty-seven counties responded. Two counties reported no out-of-wedlock births to minors. The people who answered the questions were chiefly front-line social service workers; the ones who were responsible for implementing the mandate. A scattered group of supervisors and executive directors were interviewed for their administrative observations. Confidentiality was assured.

Counties were grouped by population into small, medium, and large categories (see map). Approximately 1,775 minor mothers had been served under this legislation at the time of the interviews. Table 1 shows how the births clustered according to county size.

Findings

Wide variations occurred in implementing the mandate, despite the specificity of the legislation.

• Referrals. First, hospitals were inconsistent in their referrals. Although they had been mandated to report births to minor mothers within three days, striking violations of this instruction were reported in metropolitan areas. Private, suburban hospitals were less likely to send in reports than urban, public hospitals. Even in rural areas, 44 percent of the interviews noted that referrals from hospitals were unreliable. Visit

For those mothers already known to county social services (40 percent), the school system in the metropolitan area was the chief source of referrals. In medium- and small-sized counties, the public health staff was also a significant link to county social services during the period of pregnancy. Referrals from WIC, ** relatives, physicians, and self-referrals were small in number.

Diverse methods were used to reach the minor mothers—41 percent by phone, 31 percent by letter, 6 percent by an announced home visit, and 22 percent by some combination of these methods. A broad range of introductions were used. The tone of introduction varied from friendly letters of congratulations on the birth of the baby, accompanied by the offer of services, to curt announcements of the legal nature of the case plan requirement and a warning.

* The legislation did not impose non-compliance penalties for hospitals.
** Women, Infants, and Children (WIC) is a program that aids pregnant and nursing mothers with nutrition education and vouchers for food to prevent nutritional deficiencies.

Table 1. Minor Mothers Served Under Mandatory Social Service Plan, as Reported to Survey Interviewers

<table>
<thead>
<tr>
<th>County Size</th>
<th>Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (less than 20,000)</td>
<td>236</td>
</tr>
<tr>
<td>Medium (20,000-58,000)</td>
<td>524</td>
</tr>
<tr>
<td>Large (greater than 58,000)</td>
<td>995</td>
</tr>
<tr>
<td>Total number served at time of survey</td>
<td>1,775</td>
</tr>
</tbody>
</table>

of stern consequences for failure to comply. Some social workers attempted to mask their authority with an aura of benevolence, getting their foot in the door. Others announced they were agents of the state that required a case plan.

Twenty-two percent (385) of the minor mothers had independently produced a satisfactory case management plan on their own. These were chiefly minor mothers living with their parents. Only scattered reports of resistance to the assessment were reported. In a small number of counties, social workers reported that they retreated after a sharp rebuff from the minor mother or her parents. The association with welfare was described as offensive by non-AFDC families.

For urbanized counties, locating the highly mobile teen parents was described as a problem. Two weeks or more were typically spent in tracking down the mother. Twenty percent of minor mothers were described as urban nomads, and a portion of these could not be located at any address.

- **Coordination.** Case planning typically involves wrap-around services from a variety of systems. County social service personnel, assuming the role of case managers, were expected to summon needed resources in public health, mental health, income maintenance, and child care; and also draft required educational plans with school districts. Of all the coordination tasks, the most troublesome was the development of the school plan. Because non-compliance with this requirement could result in a financial penalty, it was the most contentious.

Monitoring school attendance was a perplexing and unresolved issue for a significant portion of counties. In some counties (41 percent) was assigned to the financial worker. In a third of the counties, social service workers assumed this task. Large, urbanized counties reported tracking problems because of mobility, unexplained absences, and the random events that disrupt continuous school attendance.

There was no agreement on how frequently school attendance should be reported. While weekly reports were useful, few could find the time to make or get them. Disputes arose on what was a reasonable excuse. Illness of mother or child, dissatisfaction with child care arrangements, fatigue, and stress were excuses offered and often challenged. Whether sanctions should be applied became a source of conflict among the three concerned units—the school, AFDC, and the social services unit. There was, in addition, disagreement about whether the school system or public assistance should pay for transportation to school.

- **Services.** Crucial services were needed but not uniformly available for the mandated case plan. Transportation, child care, and alternative education were most often mentioned as unavailable to minor mothers. Thirty percent of the counties lacked alternative school programs within a reasonable distance (thirty miles) of the mother’s home. These programs were deemed necessary to respond to the disrupted education of the mothers. Remediation programs are sparse and unevenly distributed throughout the state. The expense and scarcity of child care was also cited as a significant barrier throughout the state.

In small- and medium-sized counties, housing; legal aid; Women, Infants, and Children (WIC); and chemical dependency programs which would accommodate infants were notably unavailable. In rural counties, counseling services and parent education were especially scarce.

Twenty-five percent of the social workers interviewed noted that there were no family planning services available, and transportation to get contraceptive services was frequently lacking. Twenty percent of the counties specifically refrained from any discussion of contraception. While the legislation had been conceptualized as preventive, its eleven-point plan made no mention of the need to evaluate family planning and contraceptive use. In light of the state’s avoidance of reproductive issues, it is not hard to imagine why county social service workers were hesitant to discuss this pivotal issue. Fifty percent of the counties recommended that referral to contraceptive services be specifically added to the mandatory case plan.

Minor mothers living in working poor families were usually ineligible for child care and transportation, and in many cases, they were also ineligible for health care. These services are income conditioned and generally beyond the reach of low-wage working families.

- **County Size.** The size of the county was the pivotal variable in responding to the legislative mandate. In small Minnesota counties, too few staff, too many miles, and too few resources posed significant barriers to establishing a support plan for a minor mother.

Medium-sized counties were most successful in using collaborative resources for child care, transportation, and working out satisfactory plans for school attendance. These counties typically reported collaboration to be good to excellent with family members, public health nurses, schools, income maintenance, mental health, and other community agencies while they were developing the plan. In addition, they often received pre-birth referrals from specialized school programs while the minor was still pregnant, indicating good communication between schools and county agencies.

Social workers in medium-sized counties assumed interchangeable roles as child protection workers, foster home placement workers, and agents of the court in custody studies. They absorbed the additional responsibility of case planning for minor mothers with varying degrees of tolerance for overburdened caseloads. In the large, metropolitan counties, social workers were overwhelmed with large caseloads. Their main priority was with child protection problems. Their approach to the new legislation tended to be perfunctory and somewhat dismissive. “We know when adolescent mothers are at risk; we cannot spare time and effort for those who are O.K.” They were already engaged with high risk mothers and their children. The mandatory legislation added an extra burden to an already overburdened staff.

- **Implementation.** Generally, four tasks are required to prepare a comprehensive plan for a minor mother: risk assessment; planning for education and self-sufficiency; coordinating community resources for the plan; and establishing a relationship of trust with the minor mother, so that continuity and assistance can be given during a period that is often turbulent and crisis-ridden. This requires a staff that has knowledge, skills, and time. It also requires a community with a wide range of support services.

Seventy percent of the social workers interviewed said that they did not know how to make accurate assessments of parenting skills. More than one-third had encountered intergenerational conflicts that threatened the living arrangements of minor mothers, but they did not know how to assist in resolving these disputes. Only cursory attention had been given to involving the father of the child and to the issue of declaring paternity. And, perhaps most salient, it was reported that establishing a relationship of trust with the minor mother was difficult because of the mandatory nature of the case planning.

The Dilemmas of Mandating Intervention

While structural questions were raised in this study—such as services needed but not available or an overburdened social service system—the ideological issue underlying the mandate is even more problematic. Can an effective prevention strategy be mounted when it is anchored in the intimidating authority of a state law which directs every minor mother to be involved with a county social service system, especially when the law specifies penalties for noncompliance?

From the political perspective, the response to this question is an unhesitating yes. Indeed, the law is politically appealing, because it satisfies the yearning to do something to appease an impatient public concerned with the social and fiscal costs of children bearing children. From the perspective of the county social services, however, the response is mixed, as it is, also, from the perspective of the minor mothers.
Without an appropriation to implement the statute, this add-on to an already overburdened county social service system tended to create a symbolic response. The interviews did reveal the commitment of caseworkers to the concerns of minor mothers and their willingness to try and engage them in case planning. They used whatever time they could find to scrounge services for their clients. In two counties, brochures were prepared to assist teenage mothers in finding needed services. In scattered counties, small support groups were initiated. In one county, a group to assist fathers in parenting was developed.

In fact, 65 percent of the social workers interviewed approved of the legislation, because it gave them a foot in the door. But, the chilling effect of being seen as surveillance agents of the state was generally acknowledged. Many social workers took the time to convince minor mothers that they were not child protection workers. (Though in fact, 65 percent do have child protection responsibilities for their counties.)

“We inform them that the mandate is to make sure that they have healthy babies. We say, ‘These are your services. We are not here to take your baby away.’”

More than a third of the social workers interviewed (35 percent) had reservations about the legislation. They spoke of haves, non-AFDC minor mothers, and the have nots, AFDC mothers. They said that minor mothers on AFDC were treated as mandatory clients while non-AFDC mothers were treated as voluntary participants because the penalties were chiefly tied to reductions in the AFDC grant.

“After all, we’re not child protection. Some minor mothers who are not caught up in the welfare system flat out refuse to see us, and we have no leverage to make an invited visit.”

This, in fact, was a misinterpretation since non-AFDC mothers could have been referred to child protection for non-compliance.

In addition, because suburban hospitals were inconsistent in reporting births to minor mothers, non-AFDC mothers (who tended to use suburban hospitals) did not as often come under the surveillance of the county as did their urban AFDC peers.

A small number of social workers (9 percent), reported that the legislation was considered intrusive and a violation of privacy by non-AFDC families. In these instances, various degrees of outrage were expressed as to the right of welfare to spy into family affairs.

The study did not interview minor mothers, directly, but caseworkers were asked to describe how the mothers reacted to the legislation. A sizable proportion reported that minor mothers viewed themselves as involuntary clients, and the case planning process as an unnecessary interference in their lives. Only those mothers who had been referred to county social services through the school system while they were pregnant (approximately 40 percent), accepted the case planning process. These mothers had a relationship with a caseworker and understood that the county had resources which they needed (such as child care, health services, and referrals to

County social workers are required to work with minor mothers to develop a plan for the mother and her child. This study suggests that minor mothers, seeing themselves as involuntary clients, are reluctant to engage in genuine case planning.
Policy Issues

Minnesota's response to children having children was a comprehensive menu of social services, wrapped in a mandatory case plan for every mother under the age of eighteen. Three distinct issues were revealed during this study of how the law has been implemented.

First, the idea of a comprehensive social service plan for every minor mother has fallen far short of what was envisioned by the legislature. A bare bones budget, already stretched to the limit, could not deliver the additional personnel and resources needed for time-consuming case planning. A genuine preventive effort would require that community resources be available in a timely fashion and that case-workers have the time to develop trusting relationships. In this way minor mothers could be helped through the period of traumatic change from high school teenager to single parent.

At the time of the survey, a relatively small number of mothers (10 percent) were referred for protective supervision. But the period immediately following the birth of a child is the honeymoon phase, when the mother is still surrounded by family. The troublesome period, as studies have shown, comes when an intricate web of problems—school, relationships with the father and family, parenting responsibilities, and financial difficulties—converge. Yet few of the case workers we interviewed were able to make plans for follow-up, except in the most extreme cases, where abuse was suspected.

There is a long history of tension between the state and the counties in Minnesota, stemming from state directives to counties to perform costly services without a supporting budget. The mandatory social service plan for minor mothers continues the legacy of retrenchment politics established in the 1980s. Only a long-term study will reveal whether the legislation, even with all of its deficiencies, had any preventive effect.

A second issue relates to the use of county social services for a preventive strategy. The heavy authority of the county, which is closely associated with child protection, at least in the minds of adolescent mothers, raises questions. The data from this study suggest that minor mothers, seeing themselves as involuntary clients, are reluctant to engage in genuine case planning. The study implies that we cannot, with confidence, introduce broad-scale prevention within a coercive context.

No empirical studies have yet appeared that compare the effectiveness of voluntary vs. mandated participation. There is growing evidence, however, that public health workers could be used to engage minor mothers in planning an optimum future for themselves and their child. Rather than focus on their situation as a welfare problem, this strategy suggests that reconceptualizing their needs in terms of health, education, and training may be more effective. Home visits by public health nurses, for example, have proved remarkably effective in establishing preventive measures and they have been received positively by young mothers.

The third issue is an issue of civil liberties. Does mandatory case planning, which enforces surveillance of school attendance, employment, training preparation, and living arrangements, infringe on the rights to privacy of minor parents? This question was raised by a few case workers in the course of the study. The law provides no clear answers.* Some would argue that the immaturity of school-aged parents constitutes a danger to the proper care of their children and that this justifies state intervention. Others would argue that to convert a whole class of persons, in this case minor mothers, into a suspected high risk group, with no prior findings of harm to the child or refusal to engage in planning for their future, is unjustified and constitutes an unwarranted intrusion into family affairs.

Recent developments, however, have given the state both an incentive and a mandate to serve young mothers. Federal reimbursement is available for some services. And, under the recently passed Family Support Act of 1988, minor mothers who are AFDC recipients and who have not completed high school or who have little work experience are compelled to participate in an education and training program. Adolescent mothers on AFDC are one of the target groups of this welfare reform legislation, known in Minnesota as STRIDE.

Whether Minnesota maintains its interest in a mandatory case plan for all minor mothers remains to be seen. Monitoring adolescent parents by requiring them to participate in programs that will improve their life skills and lessen the risk of abuse and neglect is a well-intentioned goal. Whether mandatory case planning is an appropriate tool is in doubt, given the deficiencies uncovered in this implementation study.

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Esther Wattenberg is a professor in the University of Minnesota's School of Social Work and coordinator of CURA's programs in community and social services. This article is based on the study, "Mandatory Case Planning for Minnesota Minor Mothers and Their Children." Mabel Huber and Barbara McBain, of the Minnesota Department of Human Services, helped in developing the questionnaire and in providing access to key personnel in the state/county system. Sue Keskinen and Mary Ford, then graduate students in the School of Social Work, conducted interviews and provided staff support for the project.